MEDICAL /

DENTAL HISTORIES AND INFORMED CONSENT

Chart No._____ Date _____
Patient Name_____ Date of Birth_____
Address_____ SSN_____
_____ Home Phone_____
Employer_____ Work Phone _____
Employer Address _____ Cell Phone _____
_____ PA DL # _____
E-Mail _____

In case of an Emergency, whom can we contact (not residing with you) ?
Name _____ Phone No. _____

ACCOUNT / INSURANCE INFORMATION

Who is responsible for this account ?_____
Do you have Dental Insurance ? Yes No
If so, name of Insurance Co._____
Insurance Group No._____
Do you have coverage through your spouse or another Insurance Plan ? Yes No
If so, name of the Insurance Co._____
Whom may we thank for referring you to our office ?_____

PATIENT MEDICAL HISTORY

Name of Medical Doctor _____ Office Phone No._____
Address _____
Date of last visit with Medical Doctor ? _____
Reason for visit ?_____

Circle One

Yes	No	Are you receiving any medical care now?
Yes	No	Have you ever been hospitalized ?
		If yes, for what reason ?_____
Yes	No	Have you ever had a major operation / surgery ?
Yes	No	Are you in good general health ?
Yes	No	Have you taken any drugs or medications in the last two years ?
Yes	No	Are you taking any drugs or medications now ?
		If so, please list _____
Yes	No	Do you take any Herbal/Holistic remedies?_____
Yes	No	Have you ever taken Phen/Fen, Pondimin, Reduxx or diet aids?
Yes	No	Are you aware of any allergic or adverse reaction to any drugs or medications ? If yes, pls list_____

Have you ever been told you have :(Circle One)

Yes	No	Any Heart Ailment
		If yes, please explain_____
Yes	No	Surgically Repaired Heart Abnormalities
Yes	No	Heart Transplant
Yes	No	Prosthetic (artificial) valves
Yes	No	Previous History of Sub acute Endocarditis
Yes	No	Rheumatic Fever
Yes	No	Pacemaker
Yes	No	Heart Disease
Yes	No	Congenital Heart Defect
Yes	No	High Blood Pressure
Yes	No	Respiratory Disease
Yes	No	Tuberculoses
Yes	No	Arthritis
Yes	No	Prosthetic (artificial) Joints
		If yes, please explain_____
Yes	No	Tumors or Growths
Yes	No	Liver Disease
Yes	No	Kidney Disease
Yes	No	Stomach or Intestinal Disease
Yes	No	Blood Disease
Yes	No	Sickle Cell Disease
Yes	No	Diabetes: Recent A1-C _____
Yes	No	Any Dialysis or Shunts/Grafts
Yes	No	Hepatitis or Jaundice
Yes	No	Hemophilia or Any Bleeding Disorders: Any Ports or Catheters?
Yes	No	Compromised Immune System
Yes	No	Psychiatric or Psychological Care
Yes	No	Have you ever experienced chest pains and/or breathing difficulties?
Yes	No	Are you easily fatigued ?
Yes	No	Have you ever experienced night sweats or fevers ?
Yes	No	Have you ever experienced a sudden weight change (gain or loss) ?
Yes	No	Do you have a cough ?
Yes	No	Are you pregnant ?
Yes	No	Do you take Birth Control Pills ?
Yes	No	Have you ever had radiotherapy or chemotherapy? Any Ports or Catheters?
Yes	No	Have you ever had any Lymph Nodes removed?
Yes	No	Do you have a history of fainting or seizures ?
Yes	No	Have any wounds healed slowly or presented other complications ?
Yes	No	Are you on a special diet ?
Yes	No	Are you allergic to any materials resulting in hives,asthma,eczema,etc?
		If yes, please explain_____
Yes	No	Have you taken any steroids in the past two year?

DENTAL HISTORY

Circle One

Yes No Do you have any pain in or near your ears?

Yes No Do you have any unhealed/inflamed areas in or around your mouth?

Yes No Have you ever had local anesthetics ?

Yes No Any reactions or allergic symptoms to local anesthetics?

Yes No Any reactions or allergic symptoms to latex?

Yes No Have you ever had any dental or oral-facial surgery?

Yes No Have you ever had prolonged bleeding after an extraction ?

Yes No Do your gums bleed ?

Yes No Have you ever had instruction on the care of your gums ?

Yes No Have you ever had instruction on the correct method of brushing your teeth ?

Yes No Have you ever been told you have periodontal (gum) disease?

Yes No Do you chew on one side of your mouth ?

Yes No Do you at the present time have any dental complaints ?
If so, please explain_____

Yes No Do you habitually clench your teeth during the night or day ?

Yes No Is any part of your mouth sore to pressures or irritants such as (cold, sweets, etc.) ?
If so, location_____
When was your last dental visit ?_____
What was done at that time ?_____
When was your last full mouth x-ray ?_____

Yes No Was all of your dental treatment completed from your previous dentist ? If not, why?_____

Yes No Are you or have you ever received orthodontic(braces) treatment ?
If so, where ?_____

Yes No Is there anything you would like to change about your smile?

Yes No Do you use tobacco or tobacco products? If so, what type and how often?
_____

Consent to treatment :

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to consult the respective healthcare provider or agency, to release such information to you. I will notify the doctor of any change in my health or medications. I hereby authorize Dr. Essey to examine, take radiographs(x-rays), study models,photographs, or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of my dental needs. I also authorize Dr. Essey to perform any and all forms of treatment, medications, and therapy that may be indicated. I also consent that Dr. Essey choose and employ such assistance as deemed fit.
I also understand the use of anesthetic agents embodies a certain risk, such as possible nerve injury, hematomas(swelling), bruising , and discomfort. I understand that the responsibility for dental service provided in this office for any dependents or myself is mine, due and payable at the times the services are rendered unless financial arrangements have been made. If I have indicated that someone else or that some company will pay for the services rendered and payment is not made, I will be responsible for payment upon demand. I understand that a $55.00 cancellation fee will be billed to my account if an appointment is cancelled within 24 hours of the scheduled time. I further understand that a 1 1/2% finance charge(18%) annually will be added to any balance over 60 days, and I will also pay collection cost, including reasonable attorney's fees if charges are not paid when due.

Patient / Guardian Signature_____

I consent to and understand all of the above information _____

Date _____