Patient Medical History Form

PATIENT INFORMATION			**TODAY'S DATE:**	
Office Location:		Time and Date of Appointment:		
Patient *(First)*	*(MI)*		*(Last)*	
Mailing Address:				
	City:		*State:*	*Zip:*
Physical Address:				
	City:		*State:*	*Zip:*
Home#	*Work#*		*Cell#*	
Email Address:				
SS# :	*DOB:*		*Age:*	*Select Sex:*
Select Marital Status:		*Spouse Name:*		
Employer:		*How did you hear about the office?:*		
IN CASE OF EMERGENCY, CONTACT				
Name :			*Relationship:*	
Home#	*Work#*		*Cell#*	
PLEASE COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE				
Parent/Guardian:			*Relationship:*	
Address:				
	City:		*State:*	*Zip:*
Home#	*Work#*		*Cell#*	
SS# :			*DOB:*	
Parent/Guardian Email Address:				
DENTAL INSURANCE				
Policy Holder Name:			*Relationship:*	
Employer:		*Insurance Company:*		
Policy Holder SS#:		*Policy Holder DOB:*		
Do you have Medicare?		*If yes, please provide Medicare ID number:*		
If you have Medicaid, do you have any Other Ins?		*What is the Name of the Other Ins Company?*		
Policy Holder SS#:		*Policy Holder DOB:*		
DENTAL HISTORY				
Reason for today's visit:				
Date of your last dental visit:		*Date of most recent x-rays:*		
How often do you brush your teeth?:		*How often do you floss your teeth?:*		
Are you interested in whitening your teeth?:				
Are you interested in replacing your old metal fillings with more aesthetic tooth colored fillings?				
HEALTH HISTORY				
Physicians Name:			*Phone#*	
Are you currently taking any blood thinners? (Please include in the list below)			*Yes No*	
PLEASE LIST ALL CURRENT MEDICATIONS YOU ARE TAKING:				

PLEASE CONTINUE ON BACK ------------ PLEASE CONTINUE ON BACK----------------- PLEASE CONTINUE ON BACK------>

PLEASE SELECT YES OR NO FOR EACH ITEM BELOW

YES	NO		YES	NO		YES	NO	
		BAD BREATH			FOREIGN OBJECTS			PAIN AROUND EAR
		BLEEDING GUMS			GRINDING TEETH			PERIODONTAL TREATMENT
		BLISTERS ON LIPS OR MOUTH			GUMS SWOLLEN OR TENDER			SENSITIVITY TO COLD
		BURNING SENSATION OF TONGUE			JAW PAIN OR TIREDNESS			SENSITIVITY TO HEAT
		CHEW ON ONE SIDE OF MOUTH			LIP OR CHEEK BITING			SENSITIVITY TO SWEETS
		CLICKING OR POPPING OF JAW			LOOSE TEETH OR BROKEN FILLINGS			SENSITIVITY WHEN BITING
		DRY MOUTH			MOUTH BREATHING			SORES OR GROWTHS
		FINGERNAIL BITING			MOUTH PAIN, BRUSHING			EVER WHITENED YOUR TEETH
		FOOD COLLECTION BETWEEN TEETH			ORTHODONTIC TREATMENT			OTHER :

PLEASE SELECT YES OR NO TO INDICATE IF YOU HAVE HAD OR HAVE ANY OF THE FOLLOWING

YES	NO		YES	NO		YES	NO	
		AIDS/HIV			GLAUCOMA			THYROID PROBLEMS
		ABNORMAL BLEEDING			FREQUENT HEADACHES			TUBERCULOSIS
		ALLERGIES			HEART MURMUR			VENEREAL DISEASES
		ANGINA PECTORIS			HEART ATTACK			TAKEN FEN-PHEN
		ANEMIA			HEMOPHILIA			CIGARETTE PIPE, CIGAR USE
		ARTHRITIS, RHEUMATISM			HEPATITIS TYPE			ALLERGIC TO ASPIRIN
		ARTIFICIAL HEART VALVE			FEVER BLISTERS/HERPES			ALLERGIC TO BARBITUATES
		ARTIFICIAL BONES/JOINTS			HIGH BLOOD PRESSURE			ALLERGIC TO CODEINE
		ASTHMA			KIDNEY PROBLEMS/DISEASE			ALLERGIC TO DENTAL ANESTHETIC
		BLOOD TRANSFUSION			LIVER DISEASE			ALLERGIC TO ERYTHROMYCIN
		CANCER:CHEMO OR RADIATION			LOW BLOOD PRESSURE			ALLERGIC TO JEWELRY
		DRUG ABUSE			MITRAL VALVE PROLAPSE			ALLERGIC TO LATEX
		COLITIS			PACE MAKER			ALLERGIC TO METALS
		CONGENITAL HEART DEFECT			PRE-MEDICATE FOR DENTAL VISITS			ALLERGIC TO PENICILIN
		COUGH PERSISTENT/BLOODY			PSYCHIATRIC PROBLEMS			ALLERGIC TO SULFA
		DIABETES			REFLUX			ALLERGIC TO TETRACYCLINE
		DIFFICULTY BREATHING			RHEUMATIC FEVER			ALLERGIC TO OTHERS
		EMPHYSEMA			SHINGLES			PLEASE LIST
		EPILEPSY/SEIZURES			SICKLE CELL ANEMIA			
		FAINTING OR DIZZINESS			STROKE			

FEMALES ONLY - PLEASE CHECK YES OR NO TO EACH OF THE FOLLOWING

YES	NO		YES	NO		YES	NO	
		ARE YOU TAKING BIRTH CONTROL			ENTERED MENOPAUSE			TAKE(N) FOSAMAX PLUS D
		ARE YOU NURSING			TAKE(N) ACTONEL			TAKE(N) SKELID
		ARE YOU PREGNANT			TAKE(N) BONIVA			TAKE(N) AREDIA
		# OF WEEKS			TAKE(N) DIDRONEL			TAKE(N) BONEFOS
					TAKE(N) FOSAMAX			TAKE(N) ZOMETA

I request and authorize Koren Dental Management Inc, and any of it's associates to examine, clean, and provide my/the patient's dental treatment as necessary. I further request and authorize the taking of dental x-rays/photographs as may be considered necessary for diagnostic or educational purposes. I understand that this office only uses composite (tooth-colored filling material to restore teeth and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.

Print Patient/Guardian Name

Signature **Date**