# HURON DENTAL

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## *PATIENT HISTORY*

Account No. _____ (Office use only)

MR
MRS
MISS
MS

Name _____ Date _____
First Middle Initial Last

Address _____ City _____ Zip _____ Home Ph. _____

Marital Status _____ Date of Birth _____ SS# _____ Driver's License # _____

Business Name and Address _____ Business Ph. _____ Occupation _____

Patient's Dental Insurance Carrier _____ Group # _____

Email address _____ Cell Phone # _____

How would you like to be contacted? ☐Email ☐ Text ☐ Call

In Case of Emergency Contact: Name _____ Phone # _____

Name of Spouse _____ Spouse's Date of Birth _____ SS# _____

Spouse's Employer _____ Occupation _____

Spouse's Business Address _____ Business Ph. _____

Spouse's Dental Insurance Carrier _____ Group # _____

Name of person responsible for account payment _____

Address _____ City _____ Zip _____ Phone # _____

New Patients: When was your last dental visit? _____

Who was your previous dentist? Name _____ Address _____

Patient's Physician _____ Address _____ City _____ Ph. # _____

Who referred you to our office? Yellow Pages _____ Internet _____ Relative or Friend (name) _____

What is your chief complaint today? _____

Are you or have you been experiencing pain in your face or mouth? _____

Do you have any dental condition which you believe requires immediate attention today? _____

Have you ever had an injury to your face or jaw in the past? _____

Have you had any serious trouble associated with any previous dental treatment? _____

## Acknowledgement of Receipt of this Practices Privacy Notice

**I acknowledge that I have received, and/or reviewed the notice of the Privacy practices of this office.**

_____ _____

**Patient or Patient Representative** **Date**

## *MEDICAL HISTORY*

1. Has there been any change in your general health within the past year? ☐ Yes ☐ No
2. Are you under the care of a physician? ☐ Yes ☐ No
   If so, what is the condition being treated? _____
3. The name and address of the treating physician is (if different from previous page)
   _____
4. Have you had any serious illnesses or operations? ☐ Yes ☐ No
   If so, what was the illness or operation? (Please list most recent first with year it occured)
   _____
5. Do you have any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves ☐ Yes ☐ No
   b. Heart murmur or rheumatic fever ☐ Yes ☐ No
   c. Congenital heart lesions ☐ Yes ☐ No
   d. Cardiovascular disease (heart trouble, coronary insufficiency, coronary occlusion, arteriosclerosis) ☐ Yes ☐ No
   e. High blood pressure (hypertension) ☐ Yes ☐ No
   f. Low blood pressure (hypotension) ☐ Yes ☐ No
   g. Stroke ☐ Yes ☐ No
      1. Do you have chest pain upon exertion? ☐ Yes ☐ No
      2. Are you ever short of breath after mild exercise? ☐ Yes ☐ No
      3. Do your ankles swell? ☐ Yes ☐ No
      4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ☐ Yes ☐ No
      5. Do you have a cardiac pacemaker? ☐ Yes ☐ No
   h. Any hip or knee joint or artery replacements; spinal fusion (with rods placed)? ☐ Yes ☐ No
   i. Allergies ☐ Yes ☐ No
   j. Sinus trouble ☐ Yes ☐ No
   k. Asthma ☐ Yes ☐ No
   l. Hives or skin rashes ☐ Yes ☐ No
   m. Thyroid problems ☐ Yes ☐ No
   n. Diabetes ☐ Yes ☐ No
      (The following may be signs of diabetes)
      1. Do you have to urinate (pass water) more than six times a day? ☐ Yes ☐ No
      2. Are you thirsty much of the time? ☐ Yes ☐ No
      3. Does your mouth frequently become dry? ☐ Yes ☐ No
   o. Hepatitis, jaundice or liver disease ☐ Yes ☐ No
      1. If yes, Hep. A: _____ or Hep. B: _____ or Hep. C: _____
   p. Arthritis ☐ Yes ☐ No
   q. Inflammatory rheumatism (painful, swollen joints) ☐ Yes ☐ No
   r. Stomach ulcers ☐ Yes ☐ No
   s. Kidney trouble ☐ Yes ☐ No
   t. Tuberculosis ☐ Yes ☐ No
   u. Do you have a persistent cough or cough up blood? ☐ Yes ☐ No
   v. Venereal disease ☐ Yes ☐ No
   w. Epilepsy - Fainting spells or seizures ☐ Yes ☐ No
   x. Psychiatric problems or treatment ☐ Yes ☐ No
   y. Cancer ☐ Yes ☐ No
   z. Other _____ ☐ Yes ☐ No
6. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No
   a. Do you bruise easily? ☐ Yes ☐ No
   b. Have you ever required a blood transfusion? ☐ Yes ☐ No
      If so, explain the circumstances: _____

7. Do you have any blood disorder such as anemia? ☐ Yes ☐ No
8. Have you had surgery, x-ray or drug treatment for a tumor, growth or other condition of your head or neck? ☐ Yes ☐ No
9. Are you taking any of the following? **Please name medication you are taking**
   a. Antibiotics or sulfa drugs ☐ Yes ☐ No
   b. Anticoagulants (blood thinner) ☐ Yes ☐ No
   c. Medicine for high blood pressure ☐ Yes ☐ No
   d. Cortisone (steroids) ☐ Yes ☐ No
   e. Tranquilizers ☐ Yes ☐ No
   f. Antihistamines ☐ Yes ☐ No
   g. Aspirin Daily_____Occasionally_____ ☐ Yes ☐ No
   h. Insulin, Tolbutamide (Orinase) or similar drug ☐ Yes ☐ No
   i. Medications for heart trouble ☐ Yes ☐ No
   j. Nitroglycerin ☐ Yes ☐ No
   k. Oral contraceptive or other hormonal therapy ☐ Yes ☐ No
   l. Other_____ ☐ Yes ☐ No
   m. Are you taking or HAVE YOU EVER TAKEN any of these medications?
   Aredia, Zometa, Boniva or Fosamax ☐ Yes ☐ No
10. Are you allergic or have you reacted adversely to: Please Specify
   a. Local anesthetics (novocaine) ☐ Yes ☐ No
   b. Penicillin or other antibiotics ☐ Yes ☐ No
   c. Sulfa drugs ☐ Yes ☐ No
   d. Barbiturates, sedatives or sleeping pills ☐ Yes ☐ No
   e. Aspirin ☐ Yes ☐ No
   f. Iodine ☐ Yes ☐ No
   g. Codeine or other narcotics ☐ Yes ☐ No
   h. Latex ☐ Yes ☐ No
   i. Other_____
11. Do you have any disease, condition or problem not listed above that you think I should know about? ☐ Yes ☐ No
   If so, explain:_____
12. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ☐ Yes ☐ No
13. Do you have any clicking in your jaw on opening or closing? ☐ Yes ☐ No
14. Do you have significant headaches or neck pain? ☐ Yes ☐ No

## WOMEN

15. Are you pregnant? ☐ Yes ☐ No
16. Are you nursing? ☐ Yes ☐ No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient's signature_____ Dentist's signature_____

## CONSENT AND RESPONSIBILITY

I hereby authorize and request the performance of dental services for myself or for:_____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am ultimately financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check on their credit rating. As of April 1st, 1999 a 2% billing fee will be charged on account balances over 60 days. Repeated No Shows will be subject to a broken appointment fee of $20.00. This fee is not covered by any insurance and will be the patient's responsibility.

Patient's signature_____ Dentist's signature_____