"With Care and Concern for Over 30 Years"

CHEMUNG FAMILY DENTAL CENTER

1007 Broadway • Elmira, NY 14904
Telephone: (607) 734-2045

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MEDICAL HEALTH HISTORY

Patient's Name: ______________________ Birth Date: ______________________
Address: ______________________ City: ____________ State____ Zip ________
Marital Status: ______________________ Home Phone: ______________________
Place of Employment: ______________________ Business Phone: ______________________
Physician's Name: ______________________ Referred To Us By: ______________________

Dental Insurance Co. Name: ______________________
Most Convenient Day & Time For Your Dental Appointments: ______________________
Purpose of This First Dental Visit: ______________________

Person Financially Responsible For This Account: ______________________
Address: ______________________
Employment Name & Address: ______________________
Home Phone: ______________________
Social Security No.: ______________________

Please check the best answer, and complete the blank lines where appropriate:

Has there been any change in your health in the last few years: any serious illness or operation?. . . . ____ Yes ____ No
Have you been under medical treatment lately? . . . . ____ Yes ____ No
Have you been hospitalized in the last five (5) years? . . . . ____ Yes ____ No

Check, if you have had:

____Diabetes
____Thyroid Problems
____Arthritis
____Stroke
____Ulcers
____Heart problems
____Hepatitis (Type___)
____Radiation treatment
____Liver problems
____Kidney problems
____Weight __gain__loss
____Blood disorders
____Anemia
____Leukemia

____Bleeding problems
____Transfusions
____Asthma
____Allergies, Hives
____Swollen Ankles
____Tuberculosis
____Heart Murmur
____Recent by-pass surgery
____Heart valve replacements
____Mitral Valve Prolapse
____Pacemaker
____Prosthetic joint replacements
___Hip ___ Knee ___Etc.
____Rheumatoid Arthritis

____Lupus Erythematosus
____Chemotherapy
____Drug reactions
____Venereal disease
____ Sinus problems
____Sick headaches
____Cancer or tumors
____Epilepsy
____Mental problems
____Local anesthesia problems
____Digestive problems
____Heartburn
____Cortisone medicines
____Angina

____Emotional problems
____Blood Pressure
____Rheumatic Fever
____Fainting, Dizziness
____Immune Sys. Diseases
____Hay Fever
____Seizures
____Pneumonia, lung or breathing problems
____Viral infections herpes, shingles, mononucleosis, AIDS
____Alcoholism

Please list other conditions, diseases or problems not listed above ______________________
Please list any medication you are on now (including birth control pills) ______________________
____

Are you allergic to any medications, drugs, etc. such as a local anesthetic, penicillin, aspirin, codeine, other?. . . . . ____ Yes ____ No
Are you pregnant? If YES, what month are you in? __________ . . . . ____ Yes ____ No
How long since your last complete physical examination? ______________________

Over Please

History of any family disease or illness? . . . . ____ Yes ____ No
Is there any reason to believe that you are in a high rist group for AIDS or other immune system illness? . . . . ____ Yes ____ No
If YES, Please explain: ____

____

Have you had any injuries to your face or jaws? . . . . ____ Yes ____ No
Are any teeth sensitive to pressure, temperature, sweets? . . . . ____ Yes ____ No
Do you have any problems with ___swallowing, ___speaking ___chewing? . . . . ____ Yes ____ No
Do you smoke? . . . . ____ Yes ____ No
Are you conscious of bad breath or bad taste? . . . . ____ Yes ____ No
Do your gums bleed at times?. . . . . ____ Yes ____ No
Do your teeth drift, move, or feel loose? . . . . ____ Yes ____ No
Do you understand the meaning of periodontal disease? . . . . ____ Yes ____ No
Have you ever had treatment for your gums? . . . . ____ Yes ____ No
Do you clench, grit, or grind your teeth? . . . . ____ Yes ____ No
Are you troubled with tension headaches, ear problems, aches in the joint muscles, clicking jaw? . . . ____ Yes ____ No
Have you lost many teeth? If YES, why? ____________________________________ . . . ____ Yes ____ No
Have you had complications following extractions?. . . . . ____ Yes ____ No
Have you neglected having extracted teeth replaced? . . . . ____ Yes ____ No
Would you be interested in dental implants? . . . . ____ Yes ____ No
How often do you brush your teeth? ________________ Floss your teeth________________
How long has it been since you have been to a dentist? ______________________________
Do you desire to keep your natural teeth as long as possible? . . . . ____ Yes ____ No
Once your teeth and gums are in a healthy condition, do you desire to maintain your good dental health by regular preventive examinations and cleanings? . . . . ____ Yes ____ No
Are you dissatisfied with your dental appearance?. . . . . ____ Yes ____ No
Have you had troubles associated with previous dental experiences? If YES, please explain__________

____

Do you usually prefer a local anesthetic, such as Novocaine? . . . . ____ Yes ____ No
Would you be interested in using analgesia, a "Happy Air" for improved comfort?. . . . . ____ Yes ____ No
What are your greatest dental concerns at the present time?___________________________

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Would you like your dental fees estimated in advance? . . . . ____ Yes ____ No
Is there any reason to believe that you are in a high risk group for AIDS or other immune system illness? . . . . ____ Yes ____ No
If YES, Please explain: ____

____

Have you had any injuries to your face or jaws? . . . . ____ Yes ____ No
Would you prefer a time-payment plan for extensive treatment procedures? . . . . ____ Yes ____ No
Would you like to make appointments on a pay-as-you-go basis? . . . . ____ Yes ____ No

Please feel free to fully discuss your dental, medical, and financial concerns with us

Patient's Signature: ________________________ *Date:*______________________________

Provider's Signature: ________________________

Would you like your above signature to be placed on file for predeterminations and other dental insurance benefits?. . . . . ____ Yes ____ No