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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: ______________________________
Email: ______________________________ Cell 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.: ____

Emergency Contact ______________________________ *Phone* ______________________________

Is it okay to contact your Emergency Contact with your present medical condition? _____ *Yes* _____ *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	____Bleeding problems	____Lupus Erythematosus	____Emotional problems
____Thyroid Problems	____Transfusions	____Chemotherapy	____Blood Pressure
____Arthritis	____Asthma	____Drug reactions	____Rheumatic Fever
____Stroke	____Allergies, Hives	____Venereal disease	____Fainting, Dizziness
____Ulcers	____Swollen Ankles	____ Sinus problems	____Immune Sys. Diseases
____Heart problems	____Tuberculosis	____Sick headaches	____Hay Fever
____Hepatitis (Type___)	____Heart Murmur	____Cancer or tumors	____Seizures
____Radiation treatment	____Recent by-pass surgery	____Epilepsy	____Pneumonia, lung or breathing problems
____Liver problems	____Heart valve replacements	____Mental problems	
____Kidney problems	____Mitral Valve Prolapse	____Local anesthesia problems	____Viral infections herpes, shingles, mononucleosis, AIDS
____Weight __gain__loss	____Pacemaker	____Digestive problems	
____Blood disorders	____Prosthetic joint replacements	____Heartburn	
____Anemia	___Hip ___ Knee ___Etc.	____Cortisone medicines	
____Leukemia	____Rheumatoid Arthritis	____Angina	____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? ____________________

History of any family disease or illness? ____ 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 a joint replacement - _____knee_____ hip _____ shoulder and/or _____ toe? ____ Yes ____ No

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

Do you snore or have you been told you snore?. ____ Yes ____ No

Do you still have your tonsils?. ____ Yes ____ No

Do you wake up often when you are sleeping?. ____ Yes ____ No

Do you wake up from a night's sleep feeling refreshed or do you feel tired and groggy?. ____ Yes ____ No

Do you fall asleep during the day when you don't want to? For ex.-driving the car, stopped in traffic, watching TV, reading or just sitting down?. ____ Yes ____ No

Have you ever had a sleep study performed?. ____ Yes ____ No

Do you currently have a CPAP machine? Do you use it every night?. ____ Yes ____ No

Have you ever been diagnosed with a sleep disorder such as OSA(Obstructive Sleep Apnea) ____ Yes ____ No

Have you had troubles associated with previous dental experiences? If YES, please explain____________________

____

Do you usually prefer a local anesthetic, such as Novocain? ____ 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?____________________

____

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: ____________________

Are you interested in orthodontic treatment such as Invisalign (Clear Braces)?. ____ Yes ____ No

On a scale from 1 to 10 (10 being the highest) - how would you rate your smile?
Would you like to learn about ways it could be improved. . . . . ____ 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

Click SUBMIT button to send your completed form to our office. This button only works in Acrobat.
If you are having trouble, you can send the form in an email to: info@chemungfamilydental.com