Chemung
FAMILY DENTAL

MEDICAL HEALTH HISTORY - UPDATE

Patient's Name: ______________________ Birth Date: __________ Today's 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: ______________________ *Home Phone:* ______________________

Employment Name & Address: ______________________ *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: . . . . ____ Yes ____ No
  If YES, what: ____
- Have you undergone medical treatment for anything in the last year? . . . . ____ Yes ____ No
- Are you on any medications now (including birth control pills)? . . . . ____ Yes ____ No
  List: ____
- Do you have any allergies? . . . . ____ Yes ____ No
- Do you use dental floss daily? . . . . ____ Yes ____ No
- Have you neglected replacing missing teeth? . . . . ____ Yes ____ No
- Check is you have ever had: ___rheumatic fever or rheumatic heart disease; ___recent by-pass surgery; ___prosthetic valve replacements; ___mitral valve prolapse; ___pacemaker; ___prosthetic joint replacements; ___rheumatoid arthritis; ___lupus erythematosus; ___chemotherapy; ___high or low blood pressure; ___nervous disorders; ___hepatitis; ___venereal disease; ___ulcers; ___epilepsy; ___sinusitis; ___cancer; ___anemia; ___bleeding disorders; ___thyroid or kidney disease; ___tuberculosis; ___immune system diseases; ___other communicable diseases . . . . ____ Yes ____ No
  If YES, Please list these or others: ____

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- 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: ____________________

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

Are you interested in dental implants(tooth replacement) or other treatments to replace missing teeth?. . . . .

____Yes____No

Have you had a joint replacement - knee hip shoulder and/or ____ toe? ____Yes____No

Please list your major dental concerns at this time: ____________________

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