Chemung
FAMILY DENTAL
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MEDICAL HEALTH HISTORY

Patients' Name: _____ **Birth Date:** _____ **Today's Date:** _____

Address: _____ City: _____ State: _____ Zip: _____
Marital Status: _____ Home Phone: _____
Place of Employment: _____ Business Phone: _____
Email: _____ Cell Phone: _____
Physician Name: _____ Date last visited: _____ Phone: (___) _____
Cardiologist Name: _____ Date last visited: _____ Phone: (___) _____
Pulmonary Name: _____ Date last visited: _____ Phone: (___) _____
Dentist previous/current: _____ Date last visited: _____ Phone: (___) _____
Any dental work to be completed: _____
Latest dental x-rays taken: _____
Medical Insurance Co: _____
Dental Insurance Co. Name: _____
Insurance Subscribers DOB: _____
Social Security Number: (only needed for MetLife or Care Credit Financing) _____
Pharmacy: _____

Emergency Contact _____ Phone _____
Relationship: _____
Is it okay to contact your Emergency Contact with your present medical condition? ____ Yes ____ No

What are your goals to accomplish today? _____
_____

Would you like to learn more about any of the following services?

____ **Dental Implants** ____ **Teeth Whitening** ____ **Root Canals** ____ **Crowns/caps** ____ **Bridge**
____ **Nightguards** ____ **Sealants** ____ **Fluoride Varnish Treatments** ____ **Dentures/partials**
____ **White Colored Fillings** ____ **Oral Cancer Screenings** ____ **Sleep Apnea Tx**
____ **Nitrous (laughing gas)**

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
Please list other conditions, diseases or problems not listed below: _____
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

~~*THE HIGHEST COMPLIMENT OUR PATIENTS CAN GIVE, IS THE REFERRAL OF THEIR FAMILY AND FRIENDS.*~~

THANK YOU FOR YOUR CONFIDENCE

WE HONOR VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS

____ Alcohol Use
__ quantity ____ type
____ Allergies, Hives
____ Anemia
____ Angina
____ Arthritis
____ Asthma
____ Bleeding Disorders
____ Blood disorders
____ Blood Pressure: High or Low
____ Cancer or Tumors
____ Chemotherapy
____ Chewing Tobacco
____ Choking/gasping for air, while sleeping
____ Clench Teeth
____ Conscious of bad breath or bad taste
____ Cortisone Meds
____ Daytime tiredness
____ Depression
____ Deviated septum

____ Diabetes Type ____
____ Difficulty breathing through nose
____ Digestive Problems
____ Drug Reactions
____ Emotional Problems
____ Epilepsy
____ Fainting, dizziness
____ Grind Teeth
____ Hay Fever
____ Heart Burn
____ Heart Murmur
____ Heart problems
____ Heart Valve Replacement
____ Hepatitis (Type___)
____ Immune Sys.
____ Insomnia
____ Interrupted Sleeping
Why: _____.
____ Kidney problems
____ Leukemia
____ Liver problems

____ Local Anesthesia Problems
____ Lupus Erythematosus
____ Memory Problems
____ Mental Problems
____ Narcolepsy
____ Narcotic Use
____ Nightmares
____ Pacemaker
____ Pneumonia, lung or breathing problems
____ Problems Swallowing, speaking, or chewing
____ Prosthetic joint replacement
____ Radiation treatment
____ Recent by-pass surgery
____ Rheumatic Fever
____ Rheumatoid Arthritis
____ Seizures
____ Sick Headaches
____ Sinus Problems
____ Sleep Apnea

____ Sleep study performed
__ In-Lab __ At home
____ YR

____ Sleep Walking
____ Smoke _____
____ Snoring Problems
____ Stroke
____ Swollen Ankles
____ Thyroid Problems
____ TMJ pain
____ TMJ popping or clicking
____ Transfusions
____ Tonsil removal
____ Tuberculosis
____ Ulcers
____ Venereal Disease
____ Viral infections: herpes, shingles, AIDS/HIV, Mononucleosis
____ Weight _ gain _ loss

1. Do your gums bleed at times? ..... ____ Yes ____ No
2. Do your teeth drift, move, or feel loose? ..... ____ Yes ____ No
3. Do you understand the meaning of periodontal disease? ..... ____ Yes ____ No
4. Have you lost many teeth, If yes why? _____ ..... ____ Yes ____ No
5. Have you had complications following extractions? ..... ____ Yes ____ No
6. How often do you brush your teeth? _____ Floss teeth: _____
7. Are you dissatisfied with your dental appearance? ..... ____ Yes ____ No
8. How would you rate your smile? (1-low, 10-high) 1 2 3 4 5 6 7 8 9 10

By signing my name below, I certify that I have read the above information and answered all of the questions to the best of my knowledge. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

Print Name: _____
Signature: _____ Date: _____

Witness Name: _____
Signature: _____ Date: _____

CHEMUNG FAMILY DENTAL

ACKNOWLEDGEMENT OF RECEIPT AND CONSENT TO NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices and have been advised of how my protected health information may be used and disclosed by the office. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities, and healthcare operations of the office as described in the notice.

_____(Please Print Name)

_____(Signature)

_____(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented obtaining the acknowledgement

( ) Other (Please Specify)