Doerschuk Dental

Adult History Form

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health.

Today's Date____/_____/_____
E-mail Address_____

Name:_____
Last First Mi
I prefer to be called:_____
Male ☐ Female ☐
Birth Date___/____/_____ Age:_____
SS#:_____
Home Address_____
_____
City State Zip

Single___ Married___Partnered___Divorced/Separated___ Widowed___

Hm#: (___)_____Cell/Other#:(___)_____
Wk#:(___)_____ EXT:_____ DL#:_____

Employer:_____
Employer's Address_____
_____

How long there?_____ Occupation:_____
Where & when are the best times to reach you?_____
Whom may we thank for referring you?_____
Other family members seen by us:_____
Previous/Present Dentist:_____

Person responsible for account:
_____

Spouse Information

His/Her Name:_____
Employer:_____
Wk#:(___)_____Ext:_____SS#_____
Birthdate:_____/_____/_____ DL#:_____
Relative or Friend NOT living with you (for emergency).
His/Her Name_____
Relation:_____
Work #:(___)_____Ext:_____
Home#:(___)_____

INSURANCE

Primary Insurance

Dental Coverage? YES☐ NO☐
Insurance Co. Name:_____
Insurance Co. Address:_____
_____
City State zip
Ins. Co. Phone #:(___)_____
Group # (plan,local or Policy#):_____
Insured's Name_____
Relation_____
Insured's Birth date:____/____/_____
Insured's ID#:_____
Insured's Employer:_____

Secondary Insurance

Dental Coverage? YES ☐ NO ☐
Insurance Co. Names:_____
Insurance Co. Address:_____
_____
City State zip
Ins. Co. Phone #:(___)_____
Group # (plan,local or Policy#):_____
Insured's Name_____
Relation_____
Insured's Birth date:____/____/_____
Insured's ID#:_____
Insured's Employer:

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.
If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

X_____**Date**_____

Please fill out this form completely. The better we communicate, the better we can care for you.

Medical History

Do you have a personal physician?_____
Physician's Name_____
Phone #(___)_____Date of last visit:_____

Your current physical health is:

GOOD ☐ FAIR ☐ POOR ☐

Are you currently under the care of a physician?
Please explain:_____

Do you smoke or use tobacco in any other form?	Yes	No
Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath?	Yes	No
Have you had any metal rods, pins or implants?	Yes	No
Are you taking any prescription or over the counter drugs?	Yes	No

Please list each one:_____

Have you ever taken Fosamax or any other bisphosphonate? Yes No

FOR WOMEN: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Are you nursing Yes No

Have you ever had any of the following diseases or medical problems

Abdominal bleeding/Hemophilia	Y	N	Herpes/Fever Blisters	Y	N
Aids	Y	N	High Blood Pressure	Y	N
Alcohol/Drug abuse	Y	N	HIV	Y	N
Anemia	Y	N	Hospitalized for any reason	Y	N
Arthritis	Y	N	Kidney Problems	Y	N
Artificial Bones/Joints/Valves	Y	N	Liver Disease	Y	N
Asthma	Y	N	Low Blood Pressure	Y	N
Blood Transfusion	Y	N	Lupus	Y	N
Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse	Y	N
Colitis	Y	N	Pacemaker	Y	N
Congenital Heart Defect	Y	N	Psychiatric Treatment	Y	N
Diabetes	Y	N	Radiation Treatment	Y	N
Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever	Y	N
Emphysema	Y	N	Seizures	Y	N
Epilepsy	Y	N	Shingles	Y	N
Fainting Spells	Y	N	Sickle Cell Disease/Traits	Y	N
Frequent Headaches	Y	N	Sinus problems	Y	N
Glaucoma	Y	N	Stroke	Y	N
Hay Fever	Y	N	Thyroid Problems	Y	N
Heart Attack/Surgery	Y	N	Tuberculosis (TB)	Y	N
Heart Murmur	Y	N	Ulcers	Y	N
Hepatitis	Y	N	Venereal Disease	Y	N

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Aspirin	Y N	Erythromycin	Y N	Penicillin	Y N
Codeine	Y N	Jewelry/Metals	Y N	Tetracycline	Y N
Dental Anesthetics	Y N	Latex	Y N	Other	

Please list any other drugs/materials that you are allergic to:

_____

_____

Dental History

Why have you come to the dentist today?

_____

Are you currently in pain?	Yes	No
Do you require antibiotics before dental treatment?	Yes	No

Your current dental health is:

GOOD ☐ FAIR ☐ POOR ☐

Have you ever had a serious/difficult problem associated with any previous dental work?			Yes	No
Do you floss daily?	Yes	No	Brush daily?	Yes No
Type of bristles on your tooth brush?	**Hard**	**Medium**	**Soft**	
Have you ever had gum treatment?			Yes	No
Do your gums ever bleed?	Yes	No	Ever itch?	Yes No
Have you ever had periodontal disease?			Yes	No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?			Yes	No
Are your teeth sensitive to hot, cold or anything else?			Yes	No
Do you have any loose teeth?			Yes	No
Do you still have wisdom teeth?			Yes	No
Would you like fresher breath?	Yes	No	Whiter teeth?	Yes No
Are you happy with the way your smile looks?			Yes	No

If not, what would you change?

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this form will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X_____ Date_____

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit?

If yes, please explain. _____

_____

X_____
Patient Signature Date

X_____
Dentist Signature Date

Has there been any change in your health status since your last visit?

If yes, please explain. _____

_____

X_____
Patient Signature Date

X_____
Dentist Signature Date

Doerschuk Dental

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA