Bassett Creek DENTAL

Medical History **Account #** ____________________

Patients Name ______________________________ Birthdate ____/____/____ Sex ________
Your Physician ______________________________ Specialty ________________ How Long?__________
Office Address ______________________________ Phone #____________________
Are you under a physician's care now? Why?______________________________
Have you been hospitalized in the last two years? Why?______________________________
Are you taking any medications, pills, or drugs? (Please list) ______________________________
____
Are you allergic to any medication, substance or latex? (Please list) ______________________________
____
Patients email address______________________________
Emergency contact name and number______________________________
Do you smoke? Yes / No
Women: Are you pregnant? Yes / No Are you taking birth control pills? Yes / No

Please circle if you have had any of the following:

Heart Trouble	Fainting or Dizziness	Frequent Cough	Cortisone Treatment
High/Low Blood Pressure	Stroke	Lung Disease	Glaucoma
Heart Murmur	Diabetes	Tuberculosis	Epilepsy or Seizures
Rheumatic Fever	Excessive Thirst	Liver Disease	Extreme Nervousness
Congenital Heart Problem	Artificial Joints	Hepatitis A or B	Hypoglycemia
Artificial Heart Valve	Kidney Trouble	Yellow Jaundice	Psychiatric Care
Heart Pacemaker	Ulcers	Cancer	Chemical Dependency
Heart Surgery	Allergies	Thyroid Disease	Blood Transfusion
Blood Disease	Scarlet Fever	Parathyroid Disease	Hemophilia
Anemia	Asthma	X-Ray or Cobalt Treatment	AIDS or HIV Positive
Chest Pain	Hay Fever	Chemotherapy	Venereal Disease
Shortness of Breath	Sinus Trouble	Arthritis/Gout	Cold Sores/Fever Blisters
Swelling of Feet/Ankles/Hands	Emphysema	Rheumatism	Excessive Bleeding

Have you had any other serious illness not circled above? ______________________________
____
Is there anything else that would be valuable for us to know? ______________________________
____
I hereby certify that the forgoing information is correct. If there are any changes in my medical history I will notify my dentist. I authorized the dental office to perform those procedures necessary to accomplish the agreed upon treatment.
Patient's Signature ______________________________ Date ____________________
Recorded by ______________________________ DDS Signature ____________________
Updates:--

Date	Changes	Pat. Sign.	DDS/RDH Sign.

Form continues on back

Dental History

Previous Dentist ________________________________ City ____________________ How Long ______
When was your last visit to a dentist? ______________________________ X-rays taken? _______________
What did you have done at that visit? ____
What is the primary reason for your visit today? ____
How often do you brush? __________ Floss? _________ Visit the dentist? _________

Please circle if you have or had any of the following:

Head or Neck Injuries	Orthodontic Treatment
Sore or Sensitive Teeth	Periodontal Treatment
Bleeding Gums	Wisdom Teeth Extraction
Habit of Grinding or Clenching your teeth	Trouble with your jaw joint (TMJ)
Difficulty chewing	Adverse reaction to local anesthetics (Novocaine)
Anxiety because of dental treatment	Excessive bleeding or slow healing after a tooth extraction
Sores on lips or mouth that are slow to heal	Dissatisfaction with the appearance of your teeth

Is there anything else that would be valuable for us to know? ____
____

Has any dental treatment been recommended to you that has not been done? ___________________________
____

How did you hear about Bassett Creek Dental?

Family member ______________________ (name)	I am a Returning Patient
Friend/Patient ______________________ (name)	Building Sign (location)
Staff Member ______________________ (name)	Insurance
Professional Referral ______________________ (source)	Covenant Village
Internet ______________________ (source)	Friends & Family offer
Other ______________________ (source)	

Please feel free to ask any questions that you may have. Thank you.