Bassett Creek DENTAL

Medical History Form

Account # _____

Patient's Name _____ Birth Date _____ Sex _____

Your Physician _____ Specialty _____ How Long _____

Office Address _____ Phone # _____

Are you under a physician's care now? ☐ Yes ☐ No Why? _____

Have you been hospitalized in the last two years? ☐ Yes ☐ No Why? _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No (Please list) _____

_____

Are you allergic to any medication, substance or latex? ☐ Yes ☐ No (Please list) _____

_____

Do you smoke? ☐ Yes ☐ No Women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Please indicate if you have had any of the following

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

Have you had any other serious illness not indicated above? ☐ Yes ☐ No (Please list) _____

Is there anything else that would be valuable for us to know? ☐ Yes ☐ No (Please list) _____

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	Patient Signature	DDS/RDH Signature

Form continues on back side

Bassett Creek DENTAL

Medical History Form

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 indicate if you have or had any of the following

- ☐ Head or Neck Injuries
- ☐ Sore or Sensitive Teeth
- ☐ Bleeding Gums
- ☐ Trouble with your jaw joint (TMJ)
- ☐ Difficulty chewing
- ☐ Anxiety because of dental treatment
- ☐ Sores on lips or mouth that are slow to heal
- ☐ Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Wisdom Teeth Extraction
- ☐ Habit of Grinding or Clenching your teeth
- ☐ Adverse reaction to local anesthetics (Novocaine)
- ☐ Excessive bleeding or slow healing after a tooth extraction
- ☐ 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? ☐ Yes ☐ No (Please list) _____

_____

How did you hear about Bassett Creek Dental?

- ☐ Relative _____
- ☐ Friend _____
- ☐ Staff Member _____
- ☐ Health Fair/Event
- ☐ BriteSmile
- ☐ Professional Referral _____
- ☐ Yellow Pages (Minneapolis)
- ☐ Yellow Pages (Golden Valley)
- ☐ New Resident Letter
- ☐ Newspaper
- ☐ Internet
- ☐ Returning Patient
- ☐ Fitness Center
- ☐ Other _____

Did you select Bassett Creek Dental because of: ☐ Hours ☐ Location ☐ Reputation ☐ Other _____

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