AFFORDABLE DENTURES & IMPLANTS®

PATIENT HISTORY INFORMATION

Patient ID #

For office use:

Name: _____
(first name) (middle name) (last name)

Sex: ____M____F Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____

Street Address: _____

City:_____ State:_____ Zip:_____

E-Mail: _____ Home Phone:_____ Work Phone: _____

Cell:_____ Emergency Contact Name & Phone: _____

Race: ___African American ___Asian American ___Caucasian/White ___Hispanic ___Other

Name of Family Physician_____ City:_____ State: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- What is your reason for today's visit? _____

  _____
- Have you received treatment in our office previously? YES NO If so, when? _____
- How did you first learn about our affiliated dental practice providing Affordable Dentures? (circle one)

  1. Magazine 2. Newspaper 3. Radio 4. Billboards/Sign 5. Brochure/Mail
  6. Television 7. Yellow Pages 8. Friend/Relative 9. Internet/Web Site 10. Other Doctor
  11. Outside Agency
- Did you call our toll-free information service (1-800-DENTURE) YES NO
- May we provide your name to denture product companies who may wish to send you information on their products? YES NO
- May we contact you with information about special offers and new services we may offer at Affordable Dentures? YES NO If answer is YES, what is the best way to contact you?

(Please circle all methods of communication that you prefer below.)

Mail **Phone** **Email**

Do you have commercial dental insurance? YES NO Name of Insurance:_____

If yes, we will provide you with a special statement of services for use when you submit your claim.

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MEDICAL HISTORY

PATIENT NAME_____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? ○ Yes ○ No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain:_____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain:_____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Have you ever taken Fosamax, Boniva, Actonel or any _____
other medications containing bisphosphonates? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women Are You:
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain:_____

Do you have or have you ever had, any of the following:

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatment	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatiac Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disease	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Veneral Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you had any serious illnesses not listed above? ○ Yes ○ No If yes, please explain:_____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____DATE: _____