PATIENT NAME: _____

……..Mark Balenseifen DDS PC……..

PATIENT MEDICAL HISTORY:

Physician _____
Office Phone_____
Date of Last Visit _____

YES NO

[ ] [ ] Are you under medical treatment now?
[ ] [ ] Have you ever been hospitalized for any surgical operation or serious illness within the last 3 years?
If yes, explain _____
_____
_____
[ ] [ ] Are you taking any medication(s) including non-prescription medicine? If YES, what medication(s) are you taking?
_____
_____
_____

Do you NOW HAVE or HAVE YOU HAD any of the following:

YES NO

[ ] [ ] ***Diabetes***
[ ] [ ] ***High Blood Pressure***
[ ] [ ] ***Low Blood Pressure***
[ ] [ ] ***Do you use tobacco?***
[ ] [ ] **Hip or Knee or Joint Replacement/Implant**
[ ] [ ] **Heart valve or prosthetic valve repair**
[ ] [ ] **Previous Endocarditis**
[ ] [ ] **Congenital heart disease**
[ ] [ ] **Heart transplant**
[ ] [ ] ***Daily Aspirin, Blood Thinners***
[ ] [ ] **Hepatitis/Jaundice**

Are you **Allergic To** or had any **reactions** to the following?

YES NO

[ ] [ ] Local Anesthetics (for example, Novocaine)
[ ] [ ] Penicillin or any other Antibiotics
[ ] [ ] Sulfa Drugs
[ ] [ ] Barbiturates
[ ] [ ] Sedatives
[ ] [ ] Iodine
[ ] [ ] Aspirin
[ ] [ ] Any Metals (for example, nickel, mercury, etc.)
[ ] [ ] Latex Rubber
[ ] [ ] Other....PLEASE LIST_____

YES NO

[ ] [ ] Heart Attack
[ ] [ ] Rheumatic Fever
[ ] [ ] Swollen Ankles
[ ] [ ] Fainting/Seizures
[ ] [ ] Asthma
[ ] [ ] Epilepsy/Convulsions
[ ] [ ] Leukemia
[ ] [ ] Kidney Diseases, Dialysis
[ ] [ ] AIDS or HIV Infection
[ ] [ ] Thyroid Problem
[ ] [ ] Cardiac Pacemaker
[ ] [ ] Heart Murmur

YES NO

[ ] [ ] Angina, Chest Pains
[ ] [ ] Frequently Tired
[ ] [ ] Anemia
[ ] [ ] Emphysema
[ ] [ ] Cancer
[ ] [ ] Arthritis
[ ] [ ] Sexually Transmitted Disease
[ ] [ ] Stomach Troubles/Ulcers
[ ] [ ] Easily Winded
[ ] [ ] Stroke
[ ] [ ] Hay Fever/Allergies
[ ] [ ] Tuberculosis
[ ] [ ] Radiation Therapy
[ ] [ ] Glaucoma
[ ] [ ] Recent Weight Loss
[ ] [ ] Liver Disease
[ ] [ ] Respiratory Problems
[ ] [ ] Do you use controlled substances?
[ ] [ ] Are you wearing contact lenses?
[ ] [ ] Other_____

PATIENT DENTAL HISTORY

Name of Previous Dentist_____
Date of Last Dental Exam_____

YES NO

[ ] [ ] Do your gums bleed while brushing or flossing?
[ ] [ ] Teeth sensitive to hot or cold liquids/foods?
[ ] [ ] Teeth sensitive to sweet or sour liquids/foods?
[ ] [ ] Do you feel pain to any of your teeth?
[ ] [ ] Do you have sores or lumps in/near your mouth?
[ ] [ ] Have you had any head, neck or jaw injuries?

Have you ever experienced any of the following in your jaw?

[ ] [ ] Clicking
[ ] [ ] Pain (joint, ear, side of face)
[ ] [ ] Difficulty in opening or closing or chewing
[ ] [ ] Do you have frequent headaches?
[ ] [ ] Do you clinch or grind your teeth?
[ ] [ ] Do you bite your lips or cheeks frequently?
[ ] [ ] Have you had any difficult extractions in the past?
[ ] [ ] Any prolonged bleeding following extractions?
[ ] [ ] Have you had any orthodontic treatments?
[ ] [ ] Do you wear dentures or partials?

If yes, date of placement_____

[ ] [ ] Have you ever received oral hygiene instructions?
[ ] [ ] Do you like your smile?

....WOMEN ONLY....

[ ] [ ] Are you pregnant or think you may be pregnant?
[ ] [ ] Are you nursing?
[ ] [ ] Are you taking oral contraceptives?

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services and/or late fees and penalties for missed appointments or services rendered on my behalf or my dependents.

_____
Signature of patient (or parent if minor) DATE