FAMILY DENTISTRY OF CALEDONIA

ADULT MEDICAL HISTORY

Today's Date: _____

PERSONAL INFO

Name: _____

(Last) (First) (Middle initial) (Preference)

Home Address: _____

City, State, Zip: _____

Home Phone #: (_____) _____ Work # :(_____) _____

Cell Phone #: (_____) _____ Message #: (_____) _____

Birth date: _____ Age: _____ Sex: _____ Marital Status: _____

Social Security #: _____ Drivers License #: _____

Email Address: _____

EMPLOYMENT INFO

Employer: _____

Employer's Address: _____

Occupation: _____ Length of Employment: _____

SPOUSE/PARENT INFO

Spouse or Parent Name: _____

Home Address: _____

Home Phone #:_____ Cell Phone #:_____

Social Security #:_____ Date of Birth: _____

Employer: _____ Work #: (_____) _____

EMERGENCY CONTACT INFO

Name & Relation: _____ Home # (_____) _____

Work Phone #: (_____) _____ Cell # (_____) _____

DENTAL HISTORY

What is your goal for your dental care at our office? _____

How did you hear of our office? _____

Previous/ Present Dentist: _____

Last Dental Visit: _____what work was done? _____

Physician Name: _____ Phone #: (_____) _____
How would you view your current physical health? GOOD FAIR POOR

Do you have/ or had any of the following:

Artificial Bones/ Joints/ Valves	Y	N	Alcohol/ Drug Abuse	Y	N
HIV/AIDS	Y	N	Arthritis	Y	N
Diabetes	Y	N	Cancer/ Chemotherapy	Y	N
Blood Transfusion/Year_____	Y	N	Colitis/ Ulcers	Y	N
Congenital Heart Defect	Y	N	Difficulty Breathing/ Persistent Cough	Y	N
Heart Attack/ Stroke	Y	N	Emphysema/ Tuberculosis	Y	N
Date: _____			Asthma	Y	N
Heart Murmur	Y	N	Epilepsy/ Seizures/ Fainting Spells	Y	N
Heart Surgery/ Pacemaker	Y	N	Fever Blisters/ Herpes/Cold Sores	Y	N
Date: _____			Tonsillitis	Y	N
High/ Low Blood Pressure	Y	N	Headache Severe/ Frequent	Y	N
Mitral Valve Prolapse	Y	N	Kidney Problems	Y	N
Hepatitis, Type:_____	Y	N	Psychiatric Problems	Y	N
Liver Disease/ Jaundice	Y	N	Sickle Cell Disease	Y	N
Rheumatic Fever/ Scarlet Fever	Y	N	Steroid Therapy	Y	N
Date: _____			Osteoporosis	Y	N
Abnormal Bleeding/ Aspirin Use	Y	N	Thyroid Problems	Y	N

Have you ever been hospitalized for any reason? _____

ALLERGIES

Y	N	Motrin (Ibuprofen)	Y	N	Codeine	Y	N	Latex
Y	N	Dental Anesthetics	Y	N	Clindamycin	Y	N	Penicillin

Additional Allergies: _____
Please list any prescription or over the counter medication you are taking: (If you have a list we can photocopy it)
_____ _____ _____
_____

Have you ever taken Bisphosphonate drugs? (drugs for Osteoporosis) Y N

Do you use tobacco in any form? Y N Type: _____ How much: _____

FOR WOMEN: Are you taking birth control medication? Y N
Are you pregnant? Y N how many months: _____
Are you nursing? Y N

How would you view your current dental health?	GOOD	FAIR	POOR
Do you like your smile?	Y	N	
Have you ever had a serious/ difficult problem with any previous dental work?	Y	N	
Do you now or have you ever experienced pain/ discomfort in your jaw joint?	Y	N	
Have you ever had gum treatment?	Y	N	

Do your gums ever bleed? Y N If yes, when? _____
How many times per week do you floss? _____ A day do you floss? _____
How many times a day do you brush? _____
How long do you use a toothbrush before replacing it? _____ Type of bristles? _____
Are your teeth sensitive to heat, cold or anything else? _____
Have you lost any teeth? Y N If yes, why? _____

I UNDERSTAND THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGE IN MY MEDICAL STATUS. I UNDERSTAND THAT, ON THE DATE OF SERVICE, I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AS WELL AS PAYING ANY CO-PAY AND DEDUCTIBLE THAT MY DENTAL BENEFITS DOES NOT COVER. DUE TO THE INCREASED NUMBER OF BROKEN APPOINTMENTS THERE WILL BE A CHARGE OF $55.00 PER ½ HOUR OF APPOINTMENT TIME BILLED TO YOUR ACCOUNT FOR MISSED APPOINTMENTS WITHOUT 48 HOURS NOTICE. WHEN YOU MAKE AN APPOINTMENT WE CONSIDER THAT AS YOUR CONFIRMATION. WE WILL ATTEMPT A COURTESY CALL 1-2 DAYS PRIOR TO YOUR SCHEDULED TIME. HOWEVER, IF WE CANNOT REACH YOU OR YOU DO NOT GET THE MESSAGE, THE APPOINTMENT IS STILL YOUR RESPONSIBILITY.

Signature: _____ Date: _____ Relationship: _____