



**MARANA
DENTAL CARE**
"CARING FOR YOUR SMILE"

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care:

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning our health.

| | | | | | |
|--|----|-----|------------------------------------|----|-----|
| Heart Murmur (mitral valve prolapse) | No | Yes | Psychosis | No | Yes |
| Anemia | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | Previous Biopsies | No | Yes |
| Epilepsy | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Hepatitis, Any Form | No | Yes | Other Infections | No | Yes |
| Rheumatic Fever | No | Yes | Recurrent Illnesses | No | Yes |
| Asthma | No | Yes | Joint Replacement | No | Yes |
| HIV Positive or AIDS Related Complex | No | Yes | Glaucoma | No | Yes |
| Emphysema or other Respiratory Illnesses | No | Yes | Abnormal Bleeding from a cut | No | Yes |
| Abnormal Heart Condition | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Kidney Disease | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart (Surgery, Disease, Attack) | No | Yes | Latex Sensitivity | No | Yes |
| Venereal Disease | No | Yes | H.I.V. Infection/AIDS | No | Yes |

Are you taking any of these medications?

| | | | | | |
|--|----|-----|-----------------------|----|-----|
| Pre-medication before dental treatment? | No | Yes | Tagamet (Cimetidine)? | No | Yes |
| Antacids? | No | Yes | Herbal supplements? | No | Yes |
| Have you been treated with Bisphosphonate drugs? | | | | No | Yes |

Please list any medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (please circle) No Yes

If yes, what is it usually: S /D

Are you allergic or have you had a reaction to:

- a. Local anesthetics No Yes
- b. Penicillin or other antibiotics No Yes
- c. Aspirin No Yes
- d. Codeine, Valium or other sedatives No Yes
- e. Other _____

Are you a smoker? No Yes If so, how much do you smoke per day? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Weight: _____

Diet _____ Restricted Diet: _____

How many meals a day? _____

Food Allergies? _____

Sugar in your diet: None Slight Moderate High

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)

Patient Signature

Date

Doctor (Print Name)

Doctor Signature

Date

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

INFORMATION UPDATE FOR FUTURE VISITS

Have you had a change in your health since your last visit?

| | | | |
|---|--|-----------------------|--|
| Heart surgery, disease or attack | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis, Any Form | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart murmur or arterial valve prolapse | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Joint Replacement | <input type="checkbox"/> No <input type="checkbox"/> Yes | H.I.V. Infection/AIDS | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Taken Fen-phen or other diet pills | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |

Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes Are you a nursing mother? No Yes

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Do you have any allergies? No Yes List: _____

Notes: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____



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How did you hear about us? _____

Whom may we thank for referring you? _____

When you look in the mirror at your smile, what would you like to be different? _____

What would you like your teeth to be like in 20 years? _____

What is most important to you concerning your dentistry? _____

Dental History

| | Yes | No | | Yes | No |
|-----------------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|
| Bad Breath | <input type="checkbox"/> | <input type="checkbox"/> | Orthodontic Treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding gums | <input type="checkbox"/> | <input type="checkbox"/> | Pain around ear | <input type="checkbox"/> | <input type="checkbox"/> |
| Blisters on lips or mouth | <input type="checkbox"/> | <input type="checkbox"/> | Periodontal Treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning Sensation on tongue | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to cold | <input type="checkbox"/> | <input type="checkbox"/> |
| Chew on one side of mouth | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to hot | <input type="checkbox"/> | <input type="checkbox"/> |
| Cigarette, pipe or cigar smoking | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to sweets | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking or popping jaw | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity when biting | <input type="checkbox"/> | <input type="checkbox"/> |
| Dry mouth | <input type="checkbox"/> | <input type="checkbox"/> | Sores or growths in your mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| Fingernail biting | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Food collection between the teeth | <input type="checkbox"/> | <input type="checkbox"/> | How often do you floss? _____ | | |
| Foreign objects | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Grinding teeth | <input type="checkbox"/> | <input type="checkbox"/> | How often do you brush? _____ | | |
| Gums swollen or tender | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Jaw pain or tiredness | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Lip or cheek biting | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Loose teeth or broken fillings | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Mouth pain when brushing | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Patients signature _____ Date _____

Parent/Guardian Signature _____ Date _____



**MARANA
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PATIENT INFORMATION

Thank you for visiting Marana Dental Care. We want your visit to be pleasant and comfortable. Please help us by completing this form.

| | | | |
|---|-------------|----------------------|----------------|
| Name _____ | | | |
| Last _____ | First _____ | Middle Initial _____ | Nickname _____ |
| Address _____ | | | |
| City, St. _____ | | | Zip _____ |
| Phone: Home _____ | Work _____ | Mobile _____ | |
| Email _____ | | | |
| Birthdate _____ | SS. # _____ | Sex | M F |
| Spouse's Name _____ | | | |
| Employer _____ | | Driver License _____ | |
| In case of Emergency, who should we contact? _____ Phone Number _____ | | | |

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____
 Employer _____ Insurance Co. _____
 Insurance Co. Phone # _____ Group # _____
 Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____
 Employer _____ Insurance Co. _____
 Insurance Co. Phone # _____ Group # _____
 Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

IF PATIENT IS UNDER 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____ CITY STATE ZIP

Telephone (_____) _____