ESCALON FAMILY & RIPON PLAZA dental

Medical History

Do you have a personal Physician? Y N

Physicians Name_______________________________

Phone #___________________Last Visit Date______

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? Y N

If yes, please explain:__________________________

____

____

____

Are you taking any prescription/over the counter drugs? Y N

If yes, please list:_________________________________

____

____

____

____

____

____

Have you ever had any of the following diseases or medical problems?

Anemia	Y	N	Heart Surgery	Y	N
Arthritis	Y	N	Abnormal Bleeding	Y	N
Artificial Bones/Joints	Y	N	Hepatitis Type?______	Y	N
Artificial Valves	Y	N	High/Low Blood Pressure	Y	N
Asthma	Y	N	HIV+/AIDS	Y	N
Blood Transfusion	Y	N	Hospitalized (any reason)	Y	N
Cancer/Chemotherapy	Y	N	Kidney Problems	Y	N
Congenital Heart Defect	Y	N	Mitral Valve Prolapse	Y	N
Diabetes	Y	N	Psychiatric Treatment	Y	N
Difficulty Breathing	Y	N	Radiation Therapy	Y	N
Drug/Alcohol Abuse	Y	N	Rheumatic/Scarlet Fever	Y	N
Emphysema	Y	N	Shingles	Y	N
Glaucoma	Y	N	Sinus Problems	Y	N
Fainting Spells	Y	N	Tuberculosis (TB)	Y	N
Heart Attack/Stroke	Y	N	Ulcer/Colitis	Y	N
Heart Murmur	Y	N	Venereal Disease (STD)	Y	N

Please list any serious medical condition(s) that you have ever had:____

____

Are you allergic to any of the following?:

Aspirin	Y	N	Latex	Y	N
Any metals or plastics	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Other	Y	N
Erythromycin	Y	N			

Please list any other drugs/materials you are allergic to:

____

____

For Women:

Are you taking birth control?	Y	N
Are you pregnant?	Y	N
If yes, Week #:____________		
Are you nursing?	Y	N

Dental History

Are you in discomfort today?_______________

Are there any main concerns you would like the dentist to address today?__________________

____

Do you currently have:

Bad Breath	Y	N	Sometimes
Sensitivity to sweets	Y	N	Sometimes
Sensitivity to cold	Y	N	Sometimes
Loose or broken teeth	Y	N	Sometimes
Bleeding gums	Y	N	Sometimes
Sensitivity when biting	Y	N	Sometimes
Grinding or clenching	Y	N	Sometimes
Clicking or popping jaw	Y	N	Sometimes
Sores or growths in mouth	Y	N	Sometimes

How often do you brush?_________________

How often do you floss?__________________

How do you feel about the appearance of your teeth?_________________________________

Have you experienced an adverse reaction during or in conjuction with a medical or dental procedure?

____

____

____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Buchler to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Buchler.

I authorize my insurance company to pay to Buchler Dental Corporation all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Buchler Dental Corporation to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____Date_______________