McKenzie Dental Group

Date_____

PATIENT'S NAME_____ SINGLE_____
WIDOWED_____
IF CHILD, PARENT OR GUARDIAN NAME_____ MARRIED_____
DIVORCED_____
STREET ADDRESS_____ SEPARATED_____

CITY_____STATE_____ZIP_____PHONE_____

CELL PHONE_____

PATIENT EMPLOYED BY _____ BUSINESS PHONE_____

NAME OF SPOUSE_____

SPOUSE EMPLOYED BY_____BUSINESS PHONE_____

PURPOSE OF THIS APPOINTMENT_____

IN CASE OF EMERGENCY WHOM SHOULD BE NOTIFIED_____PHONE_____

WHO WILL PAY ACCOUNT_____

DO YOU HAVE DENTAL INSURANCE YES_____ NO_____

NAME OF INSURANCE COMPANY_____

PRIMARY INSURANCE SUBSCRIBER NAME_____SPOUSE NAME_____

PRIMARY SUBSCRIBER DATE OF BIRTH_____

PRIMARY SUBSCRIBER EMPLOYED BY_____

INSURANCE COMPANY CLAIMS ADDRESS_____

INSURANCE COMPANY PHONE NUMBER_____

GROUP #_____ID/SUBSCRIBER #_____

PRIMARY SUBSCRIBER SS#_____PATIENT SS#_____

MEDICAL HISTORY

1. DATE OF BIRTH_____ AGE_____ CIRCLE
2. ARE YOU HAVING PAIN OR DISCOMFORT AT THIS TIME?.....YES NO
3. DO YOU FEEL NERVOUS ABOUT HAVING DENTISTRY TREATMENT?.....YES NO
4. HAVE YOU EVER HAD A BAD EXPERIENCE IN THE DENTISTRY OFFICE?.....YES NO
5. HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE PAST TWO YEARS?.....YES NO
6. HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS?..... ...YES NO

(PLEASE SEE REVERSE SIDE)

7. HAVE YOU TAKEN ANY MEDICINE OR DRUGS DURING THE PAST TWO YEARS?.....YES NO

IF SO, LIST_____

DO YOU TAKE ASPIRIN ON A DAILY BASIS?.....YES NO

8. ARE YOU ALLERGIC TO (I.E. ITCHING, RASH, SWELLING OF HAND, FEET OR EYES) OR MADE SICK BY PENICILLIN, ASPIRIN CODINE, OR ANY DRUGS OR MEDICATION?.....YES NO

IF SO, LIST_____

9. HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT?.....YES NO

10. HAVE YOU HAD ARTIFICAIL JOINTS OR ARTIFICIAL VALVES PLACED?.....YES NO
HAS A PHYSICIAN EVER RECOMMENDED YOU TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT....YES NO

11. CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT THE PRESENT:

HEART FAILURE
HEART DISEASE OR ATTACK
ANGINA PECTORIS
HIGH BLOOD PRESSURE
HEART MURMUR
RHEUMATIC FEVER
CONGENITAL HEART LESIONS
SCARLET FEVER
ARTIEICIAL HEART VALVE
HEART PACEMAKER
HEART SURGERY
ARTIFICIAL JOINT
ANEMIA
STROKE
KIDNEY TROUBLE
ULCERS
MITRAL VALVE PROLAPSE

EMPHYSEMA
COUGH
TUBERCULOSIS (TB)
ASTHMA
HAY FEVER
SINUS TROUBLE
ALLERGIES OR HIVES
DIABETES
THYROID DISEASE
X-RAY OR COBALT TREATMENT
CHEMOTHERAPY (CANCER, LEUKEMIA)
ARTHRITIS
RHEUMATISM
CORTISONE MEDICINE
GLAUCOMA
PAIN IN JAW JOINTS

AIDS
HEPATITUS A (INFECTIOUS)
HEPATITUS B (SERUM)
LIVER DISEASE
YELLOW JAUNDICE
BLOOD TRANSFUSION
DRUG ADDICTION
HEMOPHILIA
VENEREAL DISEASE (SYPHILLIS, GONORRHEA)
COLD SORES
GENITAL HERPES
EPILEPSY OR SEIZURES
FAINTING OR DIZZY SPELLS
NERVOUSNESS
PSYCHIATRIC TREATMENT
SICKLE CELL DISEASE
BRUISE EASILY

12. WHEN YOU WALK UP STAIRS OR TAKE A WALK, DO YOU EVER HAVE TO STOP BECAUSE OF PAIN IN YOUR CHEST, OR SHORTNESS OF BREATH, OR BECAUSE YOU ARE VERY TIRED?.....YES NO

13. DO YOUR ANKLES SWELL DURING THE DAY?.....YES NO

14. HAVE YOU LOST OR GAINED MORE THAN 10 POUNDS IN THE LAST YEAR?.....YES NO

15. ARE YOU ON A SPECIAL DIET.....YES NO

16. HAS YOU MEDICAL DOCTOR EVER SAID YOU HAVE A CANCER OR TUMOR?.....YES NO

17. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED.....YES NO

IF SO, LIST_____

18. WOMEN: ARE YOU PREGNANT NOW?.....YES NO
DO YOU ANTICIPATE BECOMING PREGNANT?.....YES NO

_____
SIGNATURE

UPDATED_____INITIAL_____

UPDATED_____INITIAL_____