Dahl & Mack Dental

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www.dahlandmackdental.com

DENTAL HISTORY FORM

We are pleased to welcome you to Dahl & Mack Dental practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be happy to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name: (First)__________ (Middle Initial) ______ (Last) __________
Social Security Number: __________ Sex: ❑ M ❑ F Age: ________ Birthdate: __________
Relationship Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Address: __________ City, State, Zip Code: __________
Phone Number: __ (____) __________ Cell Phone: (___) ______-__________
E-Mail Address: __________

Patient Employed by: __________ Occupation: __________
Business Address: __________ Business Phone: (___) ______-__________
Business E-Mail: __________
Whom may we thank for referring you? __________
Notification in case of emergency: __________
Home Phone: (___) ______-__________ Cell Phone: (___) ______-__________ Business Phone: (___) ______-__________
E-Mail Address: __________

PRIMARY INSURANCE

(*Insurance information not required to be filled out. Please bring your insurance card to the first appointment.*)

Person Responsible for Account: Name: (First)__________ (Middle Initial) ______ (Last) __________
Relation to Patient: __________ Birthdate: __________ Social Security #: __________
Address *(if different from patient)*: __________ City, State, Zip Code: __________
Phone Number: __ (____) __________ Cell Phone: (___) ______-__________
E-Mail Address: __________
Person Responsible Employed by: __________ Occupation: __________
Business Address: __________ Business Phone: (___) ______-__________
Business E-Mail: __________
Insurance Company: __________ Phone Number: __ (____) __________
Insurance E-mail: __________
Contract # __________ Group # __________ Subscriber # __________
Name of other dependents under this plan:__________

SECONDARY INSURANCE

(*Insurance information not required to be filled out. Please bring your insurance card to the first appointment.*)

Is patient covered by additional insurance: ❑ Yes ❑ No
Subscriber Name: __________ Relation to Patient: __________ Birthdate: __________
Address *(if different from patient)*: __________ City, State, Zip Code: __________
Phone Number: __ (____) __________ Cell Phone: (___) ______-__________ Social Security #: __________
E-Mail Address: __________
Subscriber Employed by: __________ Occupation: __________
Business Address: __________ Business Phone: (___) ______-__________
Business E-Mail: __________
Insurance Company: __________ Phone Number: __ (____) __________
Insurance E-mail: __________
Contract # __________ Group # __________ Subscriber # __________
Name of other dependents under this plan:__________

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DENTAL HISTORY

What would you like us to do today?: ____________________ Are you in dental discomfort today?: ❑ Yes ❑ No
Former Dentist: ____________________ Address: ____________________
Dentist E-Mail: ____________________ Phone: ____________________
Date of last dental care: ____________________ Date of last x-rays: ____________________
Check (✔) yes or no if you have had problems with any of the following:

❑ Yes ❑ No	Bad breath	❑ Yes ❑ No	Food collection between teeth	❑ Yes ❑ No	Periodontal treatment
❑ Yes ❑ No	Bleeding gums	❑ Yes ❑ No	Grinding or clenching teeth	❑ Yes ❑ No	Sensitivity to cold
❑ Yes ❑ No	Clicking or popping jaw	❑ Yes ❑ No	Loose teeth or broken fillings	❑ Yes ❑ No	Sensitivity to hot
❑ Yes ❑ No	Sensitivity to sweets	❑ Yes ❑ No	Sores or growths in mouth	❑ Yes ❑ No	Sensitivity when biting

How often do you brush?: ____________________ Floss?: ____________________
How do you feel about the appearance of your teeth?: ____________________
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Yes ❑ No
Other information about your dental health or previous treatment: ____________________

MEDICAL HISTORY

Physician's name: ____________________ Phone: ____________________
Date of last visit: ____________________ Have you had any serious illnesses or operations? ❑ Yes ❑ No
If Yes, describe: ____________________
Are you currently under physician care? ❑ Yes ❑ No If Yes, describe: ____________________
Have you ever had a blood transfusion? ❑ Yes ❑ No If Yes, give approximate date: ____________________
Have you ever taken Fen-Phen/Redux? ❑ Yes ❑ No
Have you ever had a bisphosphonate medication? Brand names include Fosamax, Actonet, Atelvia, Didronel and Boniva: ❑ Yes ❑ No
WOMEN: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control? ❑ Yes ❑ No

Check (✔) yes or no if you have had any of the following:

❑ Yes ❑ No	AIDS/HIV Positive	❑ Yes ❑ No	Fainting	❑ Yes ❑ No	Psychiatric care
❑ Yes ❑ No	Anaphylaxis	❑ Yes ❑ No	Food allergies	❑ Yes ❑ No	Rapid weight gain or loss
❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Radiation treatment
❑ Yes ❑ No	Arthritis, Rheumatism	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Respiratory disease
❑ Yes ❑ No	Artificial heart valves	❑ Yes ❑ No	Heart murmur	❑ Yes ❑ No	Rheumatic/Scarlet fever
❑ Yes ❑ No	Artificial joints	❑ Yes ❑ No	Heart problems	❑ Yes ❑ No	Shingles
❑ Yes ❑ No	Asthma	Describe: ____________		❑ Yes ❑ No	Shortness of breath
❑ Yes ❑ No	Atopic (allergy prone)	❑ Yes ❑ No	Hemophilia/Abnormal bleeding	❑ Yes ❑ No	Skin rash
❑ Yes ❑ No	Back problems	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Spina Bifida
❑ Yes ❑ No	Blood disease	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Stroke
❑ Yes ❑ No	Cancer	❑ Yes ❑ No	High blood pressure	❑ Yes ❑ No	Surgical implant
❑ Yes ❑ No	Chemical dependency	❑ Yes ❑ No	Jaw pain	❑ Yes ❑ No	Swelling of feet or ankles
❑ Yes ❑ No	Chemotherapy	❑ Yes ❑ No	Kidney disease or malfunction	❑ Yes ❑ No	Thyroid disease or malfunction
❑ Yes ❑ No	Circulatory problems	❑ Yes ❑ No	Liver disease		
❑ Yes ❑ No	Cortisone treatments	❑ Yes ❑ No	Material allergies (**latex**, wool, metal, chemicals)	❑ Yes ❑ No	Tobacco habit
❑ Yes ❑ No	Cough, persistent			❑ Yes ❑ No	Tonsillitis
❑ Yes ❑ No	Cough up blood	❑ Yes ❑ No	Mitral valve prolapse	❑ Yes ❑ No	Tuberculosis
❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Nervous problems	❑ Yes ❑ No	Ulcer/Colitis
❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Pacemaker/heart surgery	❑ Yes ❑ No	Venereal disease

Is patient currently taking any medications? If Yes, list all: ____________________
____
Does patient have drug allergies? If Yes, list all: ____________________
____

AUTHORIZATION **PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

I have reviewed the information on this questionaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist 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 ____________________