

MEDICAL HISTORY

901 Family Dentistry

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Family Name \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Former Address \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ City \_\_\_\_\_

Mother's Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ City \_\_\_\_\_

Person responsible for this account: Father \_\_\_\_\_ Mother \_\_\_\_\_ Other \_\_\_\_\_

Is child covered by welfare, or is father or mother a member of any prepaid union or insurance plan?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please answer the following:

Name of employee covered under this plan \_\_\_\_\_

His/her social security number \_\_\_\_\_

Name of union \_\_\_\_\_ Local No. \_\_\_\_\_ Group No. \_\_\_\_\_

Has patient had previous dental care under this program? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of group dental plans \_\_\_\_\_

Is this (Indicate Yes or No) First visit to a dentist \_\_\_\_\_ An Emergency \_\_\_\_\_ Are other family members a patient here \_\_\_\_\_

What, in your opinion, is the dental problem? \_\_\_\_\_

Is there now or has there ever been any of the following? (Circle) Cavities Toothache Pain Broken Tooth Extracted Teeth Straightened Teeth Gum Infection

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- 1. Are you in good health? YES NO
2. Has there been any change in youe general health within the past year? YES NO
3. My last physical exam was on
4. Are you now under the care of a physican? YES NO
a. If so what is the condition being treated?
5. The name and address of my physican is:
6. Have you had any serious illness or operation? YES NO
a. If so, what was the illness or operation?
7. Have you been hospitalized or had a serious illness within the past five (5) years? YES NO
a. If so, what was the problem?
8. Do you have or have you had any of the following diseases or problems?
a. Damaged heart valves or artificial heart valves YES NO
b. Congenital heart lesions (heart murmur) YES NO
c. Cardiovascular disease (heart trouble. heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke?) YES NO
1) Do you have pain in chest upon exertion? YES NO
2) Are you ever short of breath after mild exercise? YES NO
3) Do your ankles swell? YES NO
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? YES NO
5) Do you have a cardiac pacemaker? YES NO
d. Allergy YES NO
e. Sinus Trouble YES NO
f. Asthma or hay fever YES NO

g. Hives or skin rash	YES	NO
h. Fainting spells or seizures	YES	NO
i. Diabetes	YES	NO
1) Do you have to urinate (pass water) more than 6 times per day?	YES	NO
2) Are you thirsty much of the time?	YES	NO
3) Does your mouth frequently become dry?	YES	NO
j. Hepatitis, jaundice or liver disease	YES	NO
k. Arthritis	YES	NO
l. Inflammatory rheumatism (painful swollen joints) or joint replacement (such as hip)	YES	NO
m. Stomach ulcers	YES	NO
n. Kidney trouble	YES	NO
o. Tuberculosis	YES	NO
p. Do you have persistent cough or cough up blood?	YES	NO
q. Low blood pressure	YES	NO
r. Venereal disease	YES	NO
s. HIV (Aids)	YES	NO
t. Other _____		
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9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	YES	NO
a. Do you bruise easily?	YES	NO
b. Have you ever required a blood transfusion?	YES	NO
If so explain the circumstances _____		
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10. Do you have any blood disorder such as anemia?	YES	NO
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck?	YES	NO
12. Are you taking any drug or medicine?	YES	NO
If so, what? _____		
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13. Are you taking any of the following:		
a. Antibiotics or sulfa drugs	YES	NO
b. Anticoagulants (blood thinners)	YES	NO
c. Medicine for high blood pressure	YES	NO
d. Cortisone (steroids)	YES	NO
e. Tranquilizers	YES	NO
f. Antihistamines	YES	NO
g. Aspirin	YES	NO
h. Insulin, tolbutamide (Orinase) or similar drug	YES	NO
i. Digitalis or drugs for heart trouble	YES	NO
j. Nitroglycerin	YES	NO
k. Oral contraceptive or other hormonal therapy	YES	NO
l. Other _____		
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14. Are you allergic or have you reacted adversely to:		
a. Local anesthetics	YES	NO
b. Penicillin or other antibiotics	YES	NO
c. Sulfa drugs	YES	NO
d. Barbiturates, sedatives, or sleeping pills	YES	NO
e. Aspirin	YES	NO
f. Iodine	YES	NO
g. Codeine or other narcotics (or alcohol)	YES	NO
h. Other _____		
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15. Have you had any serious trouble associated with any previous dental treatment?	YES	NO
If so explain _____		
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16. Do you have any disease, condition, or problem not listed above that you think I should know about?	YES	NO
If so explain _____		

We Specialize in Family Dentistry

901 Family Dentistry P.A.

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In the event of a default on payment, responsible party will pay collection cost and reasonable attorney fees incurred in collection of this amount and any future outstanding balances. \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT or GUARDIAN

\_\_\_\_\_  
SIGNATURE OF DENTIST