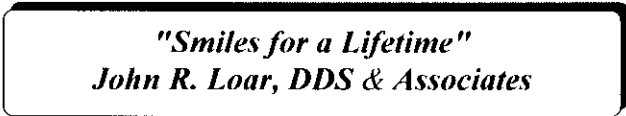


Adult



Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex \_\_\_ Home Phone \_\_\_\_\_ Preferred Name \_\_\_\_\_ Other Ph. \_\_\_\_\_

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_

Driver's License # \_\_\_\_\_ Social Security # \_\_\_\_\_ Address \_\_\_\_\_ Bus. Phone No. \_\_\_\_\_ Spouses Name \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

Please tell us who referred you to our office? \_\_\_\_\_

Dental Insurance Information (Be sure all Information is Listed) \* Insured's DOB\* \_\_\_/\_\_\_/\_\_\_

Insurance Co. Name \_\_\_\_\_ Policyholder \_\_\_\_\_ Policy or Certificate No. \_\_\_\_\_

- 1. \_\_\_\_\_
2. \_\_\_\_\_

Medical History

B.P. \_\_\_/\_\_\_

1. Are you in good health? [ ] yes, [ ] no, [ ] don't know. \_\_\_\_\_; Height - \_\_\_\_\_ Weight - \_\_\_\_\_ lb.

2. Your Physician's Name \_\_\_\_\_ Address \_\_\_\_\_

Are you under a physician's care now? [ ] no, [ ] yes -condition \_\_\_\_\_

3. List any Drugs, Herbs (over the counter or Prescription) being taken at this time(mg & times a day) \_\_\_\_\_

4. Please circle any illness you have ever had; or Systems you have had problems with:

- allergies, asthma, hepatitis, endocrine, cancer, taken Fosamax or other Bisphosphonates, tuberculosis, heart trouble, herpes, respiratory, depression or neurologic, anemia, epilepsy, venereal, urinary, skeletal, osteoporosis, kidney / or liver, rheumatic fever, high blood pressure, gastrointestinal, dermal (skin), diabetes, aids complex, glaucoma, blood disorders, arthritis or other, other

5. Have you ever had trouble with prolonged bleeding after surgery? [ ] no, [ ] yes - \_\_\_\_\_

6. Have you ever been tested for HIV (AIDS Virus)? [ ] no, [ ] yes Results: Positive [ ] Negative [ ]

7. Have you ever had any unusual reaction to anesthetic or drugs like penicillin, codeine, aspirin, iodine, or others? [ ] no [ ] yes - list \_\_\_\_\_

8. Have you ever been told by your Physician to take antibiotic pre-medication before dental treatment because of previous illness, joint replacement, mitral valve prolapse, taken Fen-Phen or Redux, or other medical treatment to prevent systemic bacteremia or SBE. [ ] no, [ ] yes - specific condition \_\_\_\_\_

9. Have you been Hospitalized in the last 15 years? \_\_\_; any blood transfusions [ ] no [ ] yes; or is there any other information that should be known about your health? \_\_\_\_\_

For Females Only

- 1. Are you pregnant? [ ] no, [ ] yes - trimester 1 2 3
2. Are you nursing? [ ] no, [ ] yes
3. Are you taking birth control pills? [ ] no, [ ] yes Name \_\_\_\_\_

MEDICAL UPDATE - REVIEW

Date \_\_\_\_\_ Signature of Patient, Parent or Responsible Party - comments \_\_\_\_\_ Initials, Asst/Hyg/ofMg/Dr \_\_\_\_\_

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

1. What concerns you the most, or reason for the dental visit? \_\_\_\_\_
2. Do you have pain in your teeth because of heat, cold, or sweets?  no,  yes - If so, where \_\_\_\_\_
3. Do you have pain in any part of the mouth or in any tooth while biting or chewing?  no,  yes - where \_\_\_\_\_
4. Does food catch between your teeth?  no,  yes - where \_\_\_\_\_
5. Do your gums bleed, either in chewing or brushing or at any other time?  no,  yes - when and where \_\_\_\_\_
6. Do you clench your teeth during the day? \_\_\_\_\_  
Have you been made aware of clenching your teeth during the night? \_\_\_\_\_
7. Do you use a stiff , or soft  bristled brush. How often do you brush a day? \_\_\_\_\_  
Do you avoid any part of your mouth while brushing? \_\_\_\_\_
8. Do your gums feel irritated, tender or swollen? \_\_\_\_\_
9. Are you completely **happy with the appearance** of your teeth?  yes,  no - why not? \_\_\_\_\_
10. Do you have all your teeth (other than wisdom teeth)?  yes,  no. \_\_\_\_\_
11. If not, did you have missing teeth replaced?  yes,  no. \_\_\_\_\_
12. Were you told why missing teeth should be replaced?  yes,  no,  n/a
13. Do you lose fillings or break silver fillings?  yes,  no,  n/a
14. Please circle, give dates, and record results if you have ever had:  
Orthodontic treatment (braces) \_\_\_\_\_ Your teeth ground or bite adjusted \_\_\_\_\_  
Oral Surgery \_\_\_\_\_ Worn a bite plate or other appliance \_\_\_\_\_  
Gum treatments or gum surgery \_\_\_\_\_ Bleaching \_\_\_\_\_
15. Do you feel Dentures are inevitable?  yes,  no. \_\_\_\_\_
16. How often do you have calculus (tartar) removed? (Professional teeth cleaning) Every \_\_\_\_\_ months.
17. Do you want to keep your teeth as long as possible?  yes,  no. \_\_\_\_\_

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services. I authorize the use of slide pictures and/or diagnostic models to be used for professional presentations. I also authorize Dr. Loar/Associates to use anesthetics and medications deemed necessary during my dental treatment and I have been encouraged to ask questions if they should arise about any medication or procedure before or during any Dental treatment. The policy of our office is the parent who requests treatment for the child is responsible for all fees for services rendered. I have received or downloaded a copy of this office's Notice of Privacy Practices (HIPAA).

\_\_\_\_\_  
Date (today)

\_\_\_\_\_  
Signature of Patient, Parent or Responsible Party

\_\_\_\_\_  
Ass/Hyg/OIMg/Dr