ADULT MEDICAL HISTORY

Name:_____ Date:_____

Please circle "Yes" or "No", or respond where indicated. Your correct answers are vital to your safe and effective treatment.

ALL INFORMATION FROM YOU, FROM THE SUBSEQUENT INTERVIEW, FROM YOUR PHYSICIAN OR ANY OTHER SOURCES, IS CONFIDENTIAL. INFORMATION WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESSED PERMISSION.

1. Are you in good health? . . . . . Yes No
2. Has there been any change in your general health in the past year?. . . . . Yes No
3. When was your last physical (medical) examination? _____
4. Are you currently under the care of any physician?. . . . . Yes No
   If yes, what is the condition being treated? _____
   _____
5. The name and address of your medical doctor(s) is(are)?
   _____ _____
   _____ _____
   _____ _____

6a. Have you ever had a serious illness, accident, operation, or been hospitalized?. . . . . Yes No
   If yes, Please Explain _____
 b. Have you ever had an accident that involved teeth, face, head or neck?. . . . . Yes No
7. Drugs and medications used in routine dental care can be incompatible with legal and illegal drugs. The effect of the combination may be dangerous to your health.
   Are you taking any drugs or medications including non-prescription medication?. . . . . Yes No
   If yes, what medication are you taking? _____
   _____
   _____

8. Do you have any of the following diseases or problems? Please **circle** those that apply.
   a. Damaged or artificial heart valves, including heart murmur or rheumatic heart disease. . . . . Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary artery disease, high blood pressure, arteriosclerosis, stroke) . . . . . Yes No
      1. Do you have chest pain on exertion?.. . . . . Yes No
      2. Are you ever short of breath after mild exercise or lying down?. . . . . Yes No
      3. Do your ankles swell?. . . . . Yes No
      4. Do you have any heart defects?. . . . . Yes No
      5. Do you have a cardiac pacemaker or defibrillator?.. . . . . Yes No
   c. Allergies. . . . . Yes No
   d. Sinus trouble.. . . . . Yes No
   e. Asthma or hay fever . . . . . Yes No
   f. Fainting spells or seizures . . . . . Yes No
   g. Persistent diarrhea or recent weight loss . . . . . Yes No
   h. Diabetes. . . . . Yes No
   I. Hepatitis, jaundice, or liver disease . . . . . Yes No
   j. AIDS or HIV infection or exposure to the HIV virus . . . . . Yes No
   k. Thyroid problems. . . . . Yes No
   l. Respiratory problems, emphysema, bronchitis, etc.. . . . . Yes No
   m. Arthritis or painful swollen joints . . . . . Yes No
   n. Stomach ulcer, reflux, or hyperacidity . . . . . Yes No
   o. Kidney trouble.. . . . . Yes No
   p. Tuberculosis. . . . . Yes No
   q. Persistent cough or cough that produces blood . . . . . Yes No
   r. Persistent swollen glands in the neck . . . . . Yes No
   s. Low blood pressure.. . . . . Yes No
   t. Sexually transmitted disease including venereal disease . . . . . Yes No
   u. Epilepsy or other neurological disease. . . . . Yes No
   v. Problems with mental health . . . . . Yes No
   w. Cancer . . . . . Yes No
   x. Problems with the immune system . . . . . Yes No

9a. Have you ever had abnormal bleeding or bruise easily? . . . . . Yes No
b. Have you ever required a blood transfusion?. . . . . Yes No
10. Do you have any blood disorder such as anemia?. . . . . Yes No
11. Have you ever had any treatment for a tumor or growth? . . . . . Yes No
12. Are you allergic to or had a reaction to:
    a. Local anesthetics . . . . . Yes No
    b. Penicillin or other antibiotic . . . . . 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 narcotic . . . . . Yes No
    h. Latex or natural rubber. . . . . Yes No
    i. Other _____
13. Have you ever had serious difficulty associated with dental care? . . . . . Yes No
    If yes, please explain _____
14. Do you have any disease, condition or problem not listed that you think we should know about?. . . . . Yes No
    Is yes, explain _____
15. Are you wearing contact lenses?. . . . . Yes No
16. Are you wearing removable dental appliances?. . . . . Yes No
17. Do you smoke or use smokeless tobacco? . . . . . Yes No

Women

18. Are you pregnant? . (Due date?_____) . . . . . Yes No
19. Are you nursing? . . . . . Yes No
20. Some drugs and medications used in routine dental care can decrease the effectiveness of birth control pills.
    Are you taking birth control pills? . . . . . Yes No

Dental History

21. Date of last dental examination or treatment:_____
22. Do you have recent dental X-rays at another office? . . . . . Yes No
23. What concerns you most? _____
24. Are you experiencing pain in your teeth, face or jaw? . . . . . Yes No
25. Are you aware of clenching or grinding your teeth?. . . . . Yes No
26. Are you experiencing:
    - ☐ Pain when biting or chewing
    - ☐ Food catching between teeth
    - ☐ Sensitivity to sweets
    - ☐ Sensitivity to cold
    - ☐ Sensitivity to heat
    - ☐ Pain or clicking in the jaw joint
    - ☐ Soreness of the jaw muscles
    - ☐ Bleeding gums
27. What are your main objectives of dental care?
    - ☐ Improve chewing
    - ☐ Eliminating pain
    - ☐ Other _____
    - ☐ Improve appearance
    - ☐ Maintaining good oral health

I certify that I have read and understand the above. I acknowledge that my concerns, if any, about the inquiries set forth above, have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

I grant the right to the dentist to release health information obtained from me and information about my dental treatment to third party payers and/or other health practitioners.

_____

Signature Date

North Coast Dental Group, LLP ● 1875 Hudson Avenue Rochester, New York 14617-5107 ● p: 585 266.9220 f: 585 266.4878 ● www.northcoastdentalgroup.net

DOCTORS NOTES AND MEDICAL HISTORY UPDATES:

NORTH COAST
DENTAL GROUP

PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____ Male: _____ Female: _____
Address: _____ Date of Birth: _____
_____ Occupation: _____
Zip Code: _____ Employer: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Pager: _____ Social Sec. #: _____
E-Mail: _____ Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced

FAMILY INFORMATION

Spouse's Name: _____ Date of Birth: _____
Address: _____ Home Phone: _____
(if different): _____ Work Phone: _____
Occupation: _____ Social Sec. #: _____
Employer: _____

Names and Ages of Children: _____
Are your children or other family members patients of our office? __ No If Yes, with which doctor?
__ Dr. Medler __ Dr. Musiker __ Dr. Shah __ Dr. Sipior __ Dr. Weiner

Is there someone we may thank for recommending our office to you? _____

-OR- How did you find out about us? _____ Print Ad _____ Yellow Pages _____ Internet

FINANCIAL / INSURANCE INFORMATION

Person Responsible for Payment: _____
Is Patient Covered By Dental Insurance: ____ YES ____ NO

PRIMARY DENTAL INSURANCE:

Subscriber's Name : _____ Date of Birth : _____
Insurance Company : _____ Employer : _____
Social Security Number: _____ Employer's Address: _____
Subscriber Number : _____ _____

SECONDARY DENTAL INSURANCE:

Subscriber's Name : _____ Date of Birth : _____
Insurance Company : _____ Employer : _____
Social Security Number: _____ Employer's Address: _____
Subscriber Number : _____ _____

Have you or any other member of your family ever been seen in this office before? ☐ Yes ☐ No