modern dental care

Welcome

PATIENT INFORMATION

Last Name_____________________ First _________________ MI _____Preferred Name _________________

Home Address ____

City _______________________________________ State ______________________Zip _________________

Date of Birth: __________________________________Social Security #: ______________________________

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other _____________________________________

Home Phone __________________________________Cell ____

Employer_____________________________________ Work # _______________________ Ext ___________

Email ____ Referred By ___________________________________

Emergency Contact ___________________________Relationship ____________Phone _________________

INSURANCE INFORMATION

Primary Insurance Company ______________________ Phone _______________________________________

Policy Holders Name ____________________________ Are you the patient? ❑ Yes ❑ No

Date of Birth _________________Social Security # ____________________ I.D. # ____________________

Employer_____________________________________ Work _______________________ Ext. ___________

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child

Secondary Insurance Company ___________________ Phone # __________________________________

Policy Holders Name ____________________________ Are you the patient? ❑ Yes ❑ No

Date of Birth _________________Social Security # ____________________ I.D. # ____________________

Employer_____________________________________ Work _______________________ Ext. ___________

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child

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Health Information

Date of last dental visit________________________ Reason for this visit______________________________

Do your gums bleed? ❑ Yes ❑ No Does your breath concern you? ❑ Yes ❑ No

Does floss shred when you use it? ❑ Yes ❑ No Do you smoke or chew tobacco/marijuana? ❑ Yes ❑ No

Have you ever had complications following dental treatment? ❑ Yes ❑ No

Please explain ____

Why did you leave your last dentist? ____

Recent surgeries or hospitalizations ❑ Yes ❑ No Reason ______________________________

Do you take or have you ever taken Bisphosphonates (Fosamax, Acetenol, Aredia & Zometa)? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No

Indicate which of the following you have had, or have at present. Check Yes or No to each item.

AIDS/HIV	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Neurological Disorders	❑ Yes ❑ No
Alcohol Abuse	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Pace Maker	❑ Yes ❑ No
Allergies (seasonal)	❑ Yes ❑ No	Excessive Bleeding	❑ Yes ❑ No	Psychiatric Problems	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Facial Surgery	❑ Yes ❑ No	Radiation/Chemotherapy	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Fainting Spells	❑ Yes ❑ No	Recreational Drug Use	❑ Yes ❑ No
Anxiety	❑ Yes ❑ No	Fever Blisters	❑ Yes ❑ No	Respiratory Problem	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Head Injury	❑ Yes ❑ No	Sensitive Teeth	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Sickle Cell Anemia	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Sinus Problems	❑ Yes ❑ No
When______________		High Blood Pressure	❑ Yes ❑ No	Stomach Problems	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Clenching/Grinding	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Thyroid Problem	❑ Yes ❑ No
Congenital Heart Defect	❑ Yes ❑ No	Liver Disease/Jaundice	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Diabetes: Type I-Type 2	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Difficulty Breathing	❑ Yes ❑ No	Nervous Disorder	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No

Have you experienced any of the following symptoms in the last 3 weeks: Chronic cough? ❑ Yes ❑ No

Bloody sputum or hemoptysis? ❑ Yes ❑ No Unexplained weight loss? ❑ Yes ❑ No

Do you have any disease, condition or problem not listed? ______________________________

Please list any and all medications you are currently taking including aspirin:______________________

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Have you ever had an ALLERGIC REACTION to any of following?

Aspirin	❑ Yes ❑ No	Metals	❑ Yes ❑ No
Codeine	❑ Yes ❑ No	Penicillin	❑ Yes ❑ No
Dental Anesthetics	❑ Yes ❑ No	Sulfa	❑ Yes ❑ No
Latex	❑ Yes ❑ No	Tetracycline	❑ Yes ❑ No

Other: ____

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have any change in my health or medications, I understand it is my full responsibility to notify Modern Dental Care.

Signature______________________________________ Date ________________