

Egalesoft Medical_Dental History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Yes No If yes _____
Have you ever been hospitalized or had a major operation? Yes No If yes _____
Have you ever had a serious head or neck injury? Yes No If yes _____
Are you taking any medications, pills, or drugs? Yes No If yes _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____
Are you on a special diet? Yes No
Do you use tobacco, pipe, cigar or smokeless tobacco? Yes No
Do you use controlled substances? Yes No If yes _____
Are you taking blood thinners? Yes No If yes _____
Do you have trouble sleeping, or have you been diagnosed with sleep apnea? Yes No If yes _____
Do you clench or grind your teeth? Yes No
Gums swollen, tender or bleeding? Yes No
Periodontal treatment? Yes No
How often do you brush? _____ How often do you floss? _____ Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Other If yes _____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No
Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No
Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Yes No
Anemia Yes No Easily Winded Yes No Herpes Yes No Rheumatic Fever Yes No
Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatism Yes No
Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes No
Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes No
Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No
Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No
Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes No
Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No
Breathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke Yes No
Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No
Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No
Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes No
Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes No
Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Ulcers Yes No
Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes No
Yellow Jaundice Yes No
Have you ever had any serious illness not listed above? Yes No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

PATIENT REGISTRATION

ID:

Chart ID:

First Name:

Last Name:

Middle Initial:

Patient Is: Policy Holder Responsible Party

Preferred Name:

Responsible Party (if someone other than the patient)

First Name:

Last Name:

Middle Initial:

Address:

Address 2:

City, State, Zip:

Pager:

Home Phone:

Work Phone:

Ext:

Cellular:

Birth Date:

Soc Sec:

Drivers Lic:

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address:

Address 2:

City:

State / Zip:

Pager:

Home Phone:

Work Phone:

Ext:

Cellular:

Sex: Male Female

Marital Status: Married Single Divorced Separated Widowed

Birth Date:

Age:

Soc Sec:

Drivers Lic:

E-mail:

I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID:

Pref. Dentist:

Employer ID:

Pref. Pharmacy:

Carrier ID:

Pref. Hyg:

Referred by:

Medical DR:

Medical DR Number:

Primary Insurance Information

Name of Insured:

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec:

Insured Birth Date:

Employer:

Ins. Company:

Address:

Address:

Address 2:

Address 2:

City, State, Zip:

City, State, Zip:

Rem. Benefits:

Rem. Deduct:

Secondary Insurance Information

Name of Insured:

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec:

Insured Birth Date:

Employer:

Ins. Company:

Address:

Address:

Address 2:

Address 2:

City, State, Zip:

City, State, Zip:

Rem. Benefits:

Rem. Deduct:



Arbor Oaks
D E N T A L

Now Let's Talk About You

Please fill out this page and bring it with you for your first appointment. This information will help us quickly understand your needs and, in the process, provide you with excellent, patient-focused service.

Our patients have found that filling out this form helps them to think about what they want out of their dental visits and how we can help in the best way possible. So, grab a pen and let us know more about you!

I decided to make an appointment because _____

My biggest concern is _____

My dental health goals for the future are _____

I would like to learn more about _____

With my new and improved smile, I hope to _____

Once I have completed my visits, I'm looking forward to _____

I'm having pain or discomfort (Circle One) YES NO

If your answer is yes, please answer these two questions:

I have the following kinds of pain _____

When I'm free of pain, I will be able to _____
