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peterson dental
KURT E. PETERSON D.D.S.

Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME www PREFERRED NAME wwwwww

Social Security No._____ Birthdate_____

Mailing Address_____Email _____

City_____State_____Zip Code_____Home Phone No. Phone

Cell Phone No. _____ How should we contact you? ☑Home ☑Cell ☑Work ☑Email ☑Text

☑Married ☑Single ☑Divorced ☑Separated ☑Widowed

Patient Occupation_____Employer_____Work Phone_____

Name of Spouse/Partner_____ Birthdate_____SSN_____

Spouse Occupation_____Employer_____Work Phone_____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name_____Home Ph. No. _____Work Ph. No. _____

Relationship to patient _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

☑Cash ☑Check ☑Bankcard ☑Other

Person responsible for payment: _____

Responsible persons address:_____Phone#_____

Primary Dental Insurance

Subscriber_____
Subscriber ID#_____
Subscriber D.O.B. _____
Subscriber Address_____
Subscriber Phone #_____
Relationship to Patient _____
Employer _____
Insurance Co._____Group# _____
Insurance Address_____
Insurance Phone #_____

Secondary Dental Insurance

Subscriber_____
Subscriber ID#_____
Subscriber D.O.B. _____
Subscriber Address_____
Subscriber Phone #_____
Relationship to Patient _____
Employer _____
Insurance Co._____Group# _____
Insurance Address_____
Insurance Phone #_____

CONSENT TO TREATMENT

I grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer upon explanation such anesthetics, analgesics, sedatives, nitrous oxide sedation; and to perfrom such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

Signature_____Date_____

MEDICAL HISTORY

Are you currently under the care of a physician? ☑Yes ☑No

Name of current physician or medical specialist City/State Phone ( )

List Medications/Herbal Supplements currently taking, dosage and condition

Check any of the following conditions which you have now or have had in the past.

- ☑**No Medical Conditions**
- ☑A.I.D.S. or H.I.V.
- ☑Allergies or Hay Fever
- ☑Angina Pectoris (Chest Pain)
- ☑Arthritis or Rheumatoid or Osteo
- ☑Artificial Heart Valve
- ☑Artificial Joints (Hip, Knee, etc.)
- ☑Asthma
- ☑Auto Immune Disorder
- ☑Congenital Heart Defect
- ☑Diabetes, Type I ☑ II ☑
- ☑Emphysema or COPD
- ☑Epilepsy or Seizures
- ☑Heart Disease or Attack
- ☑Heart Murmur or Rheumatic Fever
- ☑Heart Pacemaker
- ☑Heart Surgery
- ☑Hepatitis: A, B, C
- ☑High Blood Pressure
- ☑Kidney Failure or Disease
- ☑Liver Disease
- ☑Mental Health Condition
- ☑Premed for dental appointments
- ☑Sinus Trouble
- ☑Sleep Apnea
- ☑Stroke
- ☑Thyroid Disease or Condition
- ☑Ulcers or Intestinal Disease
- ☑Other_____

Are you allergic to or have you reacted adversely to any of the following? *(check all that apply)*

☑Aspirin ☑Codeine ☑Latex ☑Local Anesthetic ☑Penicillin ☑Other Antibiotics

*List any other allergies here:*_____

Do you Smoke? ☑Yes ☑No Use Smokeless Tobacco? ☑Yes ☑No Use E-Cigarettes? ☑Yes ☑No

Are you currently being treated for cancer or have you been treated in the past for cancer? ☑Yes ☑No Type of treatment _____

Are you or could you be pregnant? ☑Yes ☑No Are you nursing? ☑Yes ☑No Are you taking Birth Control pills? ☑Yes ☑No

Have you undergone Osteoporosis Therapy? (e.g.: Fosamax, Actonel, Boniva) ☑Yes ☑No

Are you now or have you ever been addicted to a chemical substance? (e.g.: Alcohol, Perscription Drugs, Heroin, Meth, Cocaine, Other) ☑Yes ☑No

How do you rate your sleep 1-10? _____Do you snore? ☑Yes ☑No or Have you been told that you snore? ☑Yes ☑No

Do you have any disease, condition or concern <u>not listed</u> that you believe that we should know about? (please list)

DENTAL HISTORY (Please Print)

Purpose of Appointment _____

How long since your last dental treatment_____ When was your last dental cleaning? _____

Name of previous Dentist City/State Phone ( )

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ☑Yes ☑No

Have you ever had any trouble or complications with previous dental treatment? ☑Yes ☑No

If yes, explain_____

Have you ever been diagnosed with gum disease? ☑Yes ☑No Gum treatment or surgery? ☑Yes ☑No

Do you clench or grind your teeth? ☑Yes ☑No Do you wear a nightguard? ☑Yes ☑No

Have your teeth changed in the last 5 years? ☑Yes ☑No (check all that apply) If yes, ☑shorter ☑thinner ☑worn ☑cosmetic

Are any of your teeth sensitive? ☑Yes ☑No (check all that apply) If yes, ☑ hot ☑ cold ☑ sweets ☑ pressure

Do you experience frequent (check all that apply) ☑ headaches? ☑ neck aches? ☑ shoulder aches?

Muscle pain/soreness of your face or around your ear? ☑Yes ☑No

Do you have jaw or jaw joint problems? ❑Yes ❑No If yes, (check all that apply) ❑ pain ❑ sounds ❑ limited opening ❑ locking ❑ popping

Do you have more than one bite or do you need to clench (squeeze) to make your teeth fit together? ❑Yes ❑No

Do you have difficulty with chewing gum? ❑Yes ❑No Chewy or hard foods? ❑Yes ❑No Other _____

How do you rate your smile 1-10? _____What would it take to get your smile there? _____

Where do you want it to be 1-10? _____

I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Update Record

Date	Initial

Patient Signature_____ **Date**_____

AHH 18.09.17