



# Zöe DENTAL

## Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Recent illnesses that you have now, health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes  No  If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury? Yes  No  If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation? Yes  No  If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs? Yes  No  If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux? Yes  No  If yes, please explain: \_\_\_\_\_
- Are you on a special diet? Yes  No  If yes, please explain: \_\_\_\_\_
- Have you ever had an unfavorable experience to dentistry? Yes  No  If yes, please explain: \_\_\_\_\_
- Do you premedicate before dental appointments? Yes  No  If yes, please explain: \_\_\_\_\_
- Do you use tobacco? Yes  No
- Do your gums bleed? Yes  No

- Women: Are you
- Pregnant/Trying to get pregnant       Nursing
- Taking oral contraceptives       Hormone replacement therapy

- Are you allergic to any of the following?
- Aspirin       Penicillin       Codeine       Acrylic       Metal       Latex       Local Anesthetics
- Other      If yes, please explain: \_\_\_\_\_

Do you have or have you had any of the following

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="radio"/> AIDS/HIV Positive      | <input type="radio"/> Chest Pains               | <input type="radio"/> Frequent Headaches    | <input type="radio"/> Jaundice             | <input type="radio"/> Scarlet Fever              |
| <input type="radio"/> Alzheimer's Disease    | <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Glaucoma              | <input type="radio"/> Kidney Problems      | <input type="radio"/> Shingles                   |
| <input type="radio"/> Anaphylaxis            | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Hay Fever             | <input type="radio"/> Leukemia             | <input type="radio"/> Sickle Cell Disease        |
| <input type="radio"/> Anemia                 | <input type="radio"/> Convulsions               | <input type="radio"/> Heart Attack/Failure  | <input type="radio"/> Liver Disease        | <input type="radio"/> Sinus Trouble              |
| <input type="radio"/> Angina                 | <input type="radio"/> Cortisone Medicine        | <input type="radio"/> Heart Murmur          | <input type="radio"/> Low Blood Pressure   | <input type="radio"/> Spina Bifida               |
| <input type="radio"/> Arthritis/Gout         | <input type="radio"/> Diabetes                  | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Lung Disease         | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Heart Pace Maker          | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Stroke               | <input type="radio"/> Swelling of Limbs          |
| <input type="radio"/> Artificial Joint       | <input type="radio"/> Easily Winded             | <input type="radio"/> Hemophilia            | <input type="radio"/> Jaw Pain             | <input type="radio"/> Thyroid Disease            |
| <input type="radio"/> Asthma                 | <input type="radio"/> Emphysema                 | <input type="radio"/> Hepatitis A           | <input type="radio"/> Parathyroid Disease  | <input type="radio"/> Tonsillitis                |
| <input type="radio"/> Blood Disease          | <input type="radio"/> Epilepsy or Seizures      | <input type="radio"/> Hepatitis B or C      | <input type="radio"/> Psychiatric Care     | <input type="radio"/> Tuberculosis               |
| <input type="radio"/> Blood Transfusion      | <input type="radio"/> Excessive Bleeding        | <input type="radio"/> Herpes                | <input type="radio"/> Radiation Treatments | <input type="radio"/> Tumors or Growths          |
| <input type="radio"/> Breathing Problem      | <input type="radio"/> Excessive Thirst          | <input type="radio"/> High Blood Pressure   | <input type="radio"/> Recent Weight Loss   | <input type="radio"/> Ulcers                     |
| <input type="radio"/> Bruise Easily          | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Hives or Rash         | <input type="radio"/> Renal Dialysis       | <input type="radio"/> Venereal Disease           |
| <input type="radio"/> Cancer                 | <input type="radio"/> Frequent Cough            | <input type="radio"/> Hypoglycemia          | <input type="radio"/> Rheumatic Fever      |  |
| <input type="radio"/> Chemotherapy           | <input type="radio"/> Frequent Diarrhea         | <input type="radio"/> Irregular Heartbeat   | <input type="radio"/> Rheumatism           |  |

Have you ever had any serious illness not listed above? Yes  No  If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_



ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

### Patient Registration

Last Name:		First Name:		Middle Initial:	Preferred Name:
Patient is: Policy Holder <input type="radio"/>		Responsible Party <input type="radio"/>		Child <input type="radio"/>	
Address:					
City:			State:	Zip:	
Home Phone: (    )		Work Phone: (    )		Ext:	Cell Phone: (    )
Birth Date:		Age:		Male <input type="radio"/>	Female <input type="radio"/>
Reason for this visit:					
Specific tooth concerns:				Are you presently in dental pain: Yes <input type="radio"/> No <input type="radio"/>	

### Responsible Party

Last Name:		First Name:		Middle Initial:	Preferred Name:
Marital Status: Married <input type="radio"/>		Single <input type="radio"/>		Divorced <input type="radio"/>	Separated <input type="radio"/> Widowed <input type="radio"/>
Address:			Email:		
City:			State:	Zip:	
Do you have dental insurance: Yes <input type="radio"/> No <input type="radio"/> Please bring your insurance card to first visit and anytime your insurance changes.					
How did you hear about Zöe Dental:				How long have you lived in this area?	
Do you have family members already in our practice: Yes <input type="radio"/> No <input type="radio"/>				May we ask who they are?	
Employment Status: Full Time <input type="radio"/> Part Time <input type="radio"/> Retired <input type="radio"/>			Student Status: Full Time <input type="radio"/> Part Time <input type="radio"/>		
Last Dental Visit:		Preferred Pharmacy: (    )			
Do you have current x-rays to bring: Yes <input type="radio"/> No <input type="radio"/>			Previous Dentist:		
Emergency Contact: Name:			Relationship to patient:		
Home Phone: (    )		Cell Phone: (    )		Work Phone: (    )	
Would you be interested in our complimentary Dental Anxiety Management Consultation: Yes <input type="radio"/> No <input type="radio"/>					