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

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

ZÖE DENTAL

ID:_____ Chart ID:_____

Patient Registration

Last Name: First Name: Middle Initial: Preferred Name:

Patient is: Policy Holder ○ Responsible Party ○ Child ○

Address:

City: State: Zip:

Home Phone: ( ) Work Phone: ( ) Ext: Cell Phone: ( )

Birth Date: Age: Male ○ Female ○

Reason for this visit:

Specific tooth concerns: Are you presently in dental pain: Yes ○ No ○

Responsible Party

Last Name: First Name: Middle Initial: Preferred Name:

Marital Status: Married ○ Single ○ Divorced ○ Separated ○ Widowed ○

Address: Email:

City: State: Zip:

Do you have dental insurance: Yes ○ No ○ 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 ○ No ○ May we ask who they are?

Employment Status: Full Time ○ Part Time ○ Retired ○ Student Status: Full Time ○ Part Time ○

Last Dental Visit: Preferred Pharmacy: ( )

Do you have current x-rays to bring: Yes ○ No ○ 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 ○ No ○

re: WM 10.18.07