Medical Information

Indicate which of the following you have had or have at present. Circle "Yes or No" to each item. Please answer ALL questions.

High/Low Blood Pressure ☐/☐
Heart Murmur ☐/☐
Mitral Valve Prolapse ☐/☐
Rheumatic Fever ☐/☐
Heart Disease or Attack ☐/☐
Heart Pacemaker ☐/☐
Congenital Heart Disease ☐/☐
Angina Pectoris ☐/☐
Heart Surgery ☐/☐
Heart Failure ☐/☐
Artificial Heart Valve ☐/☐
Stroke ☐/☐
Cortisone Medicine ☐/☐
Arthritis ☐/☐
Artificial Joints ☐/☐
Have you taken appetite suppressants including Fen-Phen? ☐/☐
- If yes, have you had an echocardiogram? ☐/☐

Hepatitis A (Infectious) ☐/☐
Hepatitis B (Serum) ☐/☐
Hepatitis C ☐/☐
Liver Disease/Disorder ☐/☐
Yellow Jaundice ☐/☐
Kidney Disease/Disorder ☐/☐

Cancer ☐/☐
Tumors ☐/☐
Chemotherapy ☐/☐
Radiation Therapy ☐/☐
Have you received or are you currently receiving medication known as bisphosphonates (for example, IV Zometa, Aredia, Fosamax, Actonel, or Boniva)? ☐/☐
- Have you noticed any changes in your mouth or jaws? ☐/☐
- Have you had any jaw pain or toothache? ☐/☐
- Have you noticed any foul smell, swelling or discharge in your mouth? ☐/☐

Blood Transfusion ☐/☐
If yes, what year?_____
Hemophilia ☐/☐
AIDS ☐/☐
Sickle Cell Disorder ☐/☐
Anemia ☐/☐
Bruise Easily ☐/☐
Herpes ☐/☐
Venereal Disease ☐/☐
Cold Sores/Fever Blisters ☐/☐

Tuberculosis ☐/☐
Emphysema/COPD ☐/☐
Asthma ☐/☐
Do You Use Tobacco? ☐/☐
Chronic Cough ☐/☐
Sinus Trouble ☐/☐
Hay Fever ☐/☐
Allergies or Hives ☐/☐
Diabetes ☐/☐
Thyroid Disorder ☐/☐
Migraines ☐/☐
Glaucoma ☐/☐
Epilepsy or Seizures ☐/☐
Fainting or Dizzy Spells ☐/☐
Nervous Disorder ☐/☐
Ulcers ☐/☐
Do You Drink Alcohol? ☐/☐
If yes, how much?_____
Eating Disorder ☐/☐
Drug or Alcohol Addiction ☐/☐
Are You Pregnant? ☐/☐
If yes, how many weeks?_____
Are You Nursing? ☐/☐
Are You Taking Birth Control Pills? ☐/☐
(Antibiotics may nullify effective contraception)

Please list all drugs and medications you are currently taking:

If you have ever been seriously ill or hospitalized, please explain:

Indicate which of the following drugs to which you may be allergic or sensitive. Circle yes or no for each item.

Penicillin ☐/☐
Erythromycin ☐/☐
Tetracycline ☐/☐
Sulfa Drugs ☐/☐
Other Antibiotics ☐/☐

Codeine or other narcotics ☐/☐
Aspirin ☐/☐
Demerol ☐/☐
Sedatives ☐/☐
Other Pain medication ☐/☐

Local Anesthetics ☐/☐
Non-Steroidal Drugs ☐/☐
Anti-Inflammatory Drugs ☐/☐
Latex ☐/☐
Metals ☐/☐

Do you have or have you had any disease, condition, or problems not listed? ☐/☐
If yes, please explain:_____

1. **I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all** questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs.
3. **I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and** payable at the time services are rendered unless other arrangements have been made.
4. **I understand that it is my responsibility to advise your office of any changes in the information contained in this form.**
5. I authorize release of any information relating to my insurance claims and I hereby authorize payments of the dental claim to Dr. Bruce W. Johnson if arranged prior to treatment.

Patient Signature_____ Date_____

Print Name_____

Parent or Responsible Party _____ Date_____

Reviewed by Doctor_____ Date_____

Patient Information (please print clearly)

Date _____ Patient's Name _____
Last First Nickname Marital Status

Address _____ Date of Birth _____

Home# _____ Cell# _____ Soc. Sec.# _____ Driver's Lic.# _____

Employer _____ Occupation _____ No. Yrs. Employed _____

Work# _____ Employer's Address _____

Email _____

Spouse _____ Work# _____ Cell# _____

Employer _____ Address _____

If patient is a minor, give parent's/guardian's name _____ Relationship _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Phone# _____

Emergency Contact (other than spouse) _____ Phone# _____

Responsible Party Information (if different from above)

Name _____
Last First Middle Nickname Marital Status

Residence _____

Mailing Address _____

Home# _____ Work# _____ Cell# _____

Soc. Sec.# _____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Yrs. Employed _____

Employer Address _____

Dental Insurance Information

Insured's Name _____ Insured's ID or SS# _____ Date of Birth _____

Insurance Company _____ Phone# _____ Group# _____

Do you have dual coverage? ☐/☐ If yes: Please complete the following secondary insurance information.

Insured's Name _____ Insured's ID or SS# _____ Date of Birth _____

Insurance Company _____ Phone# _____ Group# _____

Dental Information

Have you ever been informed that you have gum problems? ____ ☐/☐

Have you ever had periodontal treatment? _____ ☐/☐

Is any part of your mouth sensitive? _____ ☐/☐

If yes, check all that apply: Hot ☐ Cold ☐ Sweet ☐ Pressure ☐

Have you had an unfavorable reaction to local anesthetic? ____ ☐/☐

If Yes, Explain _____

Does dental treatment make you nervous? _____ ☐/☐

If yes, check one: Slightly ☐ Moderately ☐ Extremely ☐

At what interval are you having cleanings? _____

Are you aware of clenching or grinding your teeth? _____ ☐/☐

Have you ever experienced the following? ☐ Bleeding/swollen gums ☐ Pain/soreness in gums ☐ Receding gums ☐ Pus around teeth
☐ Loose teeth ☐ Spaces between teeth ☐ Drifting of teeth ☐ Bad breath or taste ☐ Food packing between teeth

General Dentist Name _____ Phone# _____ No. of Years _____

Whom may we thank for referring you to our office? _____

Physician's Name _____ Phone# _____ Fax _____

Address _____ Specialty _____

Are you in good health? _____ ☐/☐ If no, what is the nature of your illness? _____

Date of last physical examination: _____ Height: _____ Weight: _____ Blood Pressure: _____