Jeneen Martin DDS PC

*PATIENT NAME*_____ *TODAY'S DATE*_____
*PREFERRED OR NICKNAME*_____ *DATE OF BIRTH*_____
*HOME ADDRESS*_____ *SOCIAL SECURITY #*_____
*CITY*_____ *INSURANCE*_____
*STATE, ZIP CODE*_____ *PHYSICIAN*_____
*HOME/CELL PHONE*_____ *EMAIL*_____
*EMPLOYER*_____ *EMPLOYER'S PHONE*_____
*EMERGENCY CONTACT*_____ *EMERGENCY CONTACT#*_____
*HOW DID YOU HEAR ABOUT OUR OFFICE?*_____
*WHOM CAN WE THANK FOR REFFERING YOU?*_____

PATIENT MEDICAL HISTORY

	YES	NO
1. Are you under medical treatment now?_____	___	___
2. Have you ever been hospitalized for any surgical operation or serious illness?_____	___	___
3. Are you taking any medications including non-prescription medicine? If yes, what medication(s) _____	___	___
4. Have you ever taken Fen-Phen/Redux?	___	___
5. Do you use tobacco (smoke or chewing)?	___	___
6. Do you frequently consume alcohol?	___	___
7. Are you taking or have you taken medication for osteoporosis?_____	___	___
8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	___	___
9. Woman Only: a.) Are you pregnant or think you may be pregnant?	___	___
b.) Are you nursing?	___	___
c.) Are you taking birth control pills?	___	___

10. Are you allergic to or have you had any reaction to the following:

	YES	NO		YES	NO
a.) Local Anesthetic (eg. Epinephrine)	___	___	e.) Penicillin	___	___
b.) Barbiturates/Narcotics	___	___	f.) Sulfa	___	___
c.) Aspirin	___	___	g.) Codeine	___	___
d.) Sedatives	___	___	h.) Latex	___	___
			Other_____		

11.) Do you need to be pre-medicated for dental treatment? ___ ___

12.) Do you or have you had any of the following?

YES	NO		YES	NO		YES	NO	
___	___	AIDS or HIV Infection	___	___	Hay Fever/ Allergies	___	___	Recent Weight Loss
___	___	Angina	___	___	Heart Attack	___	___	Respiratory Problems
___	___	Anemia	___	___	Heart Disease	___	___	Rheumatic Fever
___	___	Arthritis	___	___	Heart Murmur	___	___	Sexually Transmitted Disease
___	___	Asthma	___	___	Heart Trouble	___	___	Stomach Troubles/Ulcers
___	___	Cancer	___	___	Hepatitis / Jaundice	___	___	Swollen Ankles
___	___	Cardiac Pacemaker	___	___	High Blood Pressure	___	___	Stroke
___	___	Chest Pains	___	___	Joint Replacement or Implant			
___	___	Diabetes	___	___	Kidney Disease	___	___	Thyroid Problems
___	___	Emphysema	___	___	Leukemia	___	___	Tuberculosis
___	___	Epilepsy/ Convulsions	___	___	Liver Disease	___	___	Other_____
___	___	Fainting / Seizures	___	___	Low Blood Pressure			_____
___	___	Frequently Tired	___	___	Osteoporosis			OVER PLEASE------→
___	___	Glaucoma	___	___	Radiation Therapy			REVIEWED BY_____

PATIENT DENTAL HISTORY

		YES	NO	Comment or concern
1.	Do your gums bleed while brushing or flossing?	___	___	_____
2.	Are your teeth sensitive to hot or cold liquids/foods?	___	___	_____
3.	Have you had orthodontic treatment (braces)?	___	___	_____
4.	Have you ever had any difficult extractions (pulled)?	___	___	_____
5.	Do you have any sores or lumps in or near your mouth?	___	___	_____
6.	Have you had any face, mouth, teeth, or chin injuries?	___	___	_____
7.	Do you have frequent headaches?	___	___	_____
8.	Do you clench or grind your teeth?	___	___	_____
9.	Do you bite your lips or cheeks frequently?	___	___	_____
10.	Do you have pain in any of your teeth?	___	___	_____
11.	Do you use cocaine (reacts with anesthetic)?	___	___	_____
12.	Have you ever had Nitrous Oxide (N2O)?	___	___	_____
13.	Would you be interested in Nitrous Oxide?	___	___	_____
14.	Is your water fluoridated (age 14 and under)?	___	___	_____
15.	Is your child on a fluoride supplement?	___	___	_____
16.	What was the date of your last dental cleaning/exam?	_____		

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care for the purpose of treatment and administering claims for insurance benefits, including electronic submission of claims. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. Payments in full (or estimated co-payment and insurance assignment) is expected at the time of service. I attest that the information provided on these pages are true and correct to the best of my knowledge.

_____ _____

Patient Name (printed) Patient Name (Signature)
(if minor, guardian signature)

_____ _____

Print Name (of person responsible for account) Signature (of person responsible for account)

_____ _____

Date Date