Chalet Dental Care

Name _____ Birthdate _____
last first middle intial

Marital Status _____ Soc. Sec. No. _____ Phone Number _____

Residence Address _____ City _____ State _____ Zip _____

Email Address _____ Cell Number _____

Employed By _____ Phone Number _____

May we call you at work? Yes No

Person Responsible for Account _____

Whom may we thank for referring you? _____

If you have insurance - either your own, your parent's or spouse's - which may assist you with a portion of your account, please complete the following:

Subscriber Name _____

Employer _____

Name of Insurance Company _____

Group # _____

Subscriber Soc. Sec. No. _____ Birthdate of Subscriber _____

Additional Coverage

Subscriber Name _____

Employer _____

Name of Insurance Company _____

Group # _____

Subscriber Soc. Sec. No. _____ Birthdate of Subscriber _____

When was the last time you visited a dentist and what was done? _____

_____

Were X-Rays taken? _____

Are your teeth sensitive? _____ Sweets? _____ Hot? _____ Cold? _____

Are you pleased with the appearance of your teeth? _____

Reason for appointment _____

Chalet Dental Care offeres a variety of services to our patients. Is there any of the following services you would like to know more about? Please check any of the following:

Snoring & Sleep Apnea..... Do you snore or experience daytime drowsiness?

Botox Cosmetic ..... A safe, effective way to eliminate fine lines and wrinkles.

Invisalign..... Straighten your smile the clear way. No braces needed. For all ages.

Dental Implants..... Nothing replaces your natural teeth, but dental implants can come close.

Tooth Whitening ..... A simple, cost effective way to brighten your smile.

Veneers or Crowns ..... Enhance the appearance of your smile with Natural Looking Restorations.

over...

Time 10:46 AM

Chalet Dental Care, P.A.

Med History Form

Date 1/11/2018

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. 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

Emergency Contact Name / Relationship / Phone ☐ If yes

Primary Physician Name / Location / Phone Number ☐ If yes

Have you ever been hospitalized or had a major operation? ◌ Yes ◌ No If yes

Have you ever had a serious head or neck injury? ◌ Yes ◌ No If yes

Are you taking any medications, pills, or drugs? ◌ Yes ◌ No If yes

Have you ever been required to take a Antiobiotic Pre-Medication for your dental visits? ◌ Yes ◌ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◌ Yes ◌ No If yes

Do you use tobacco?

Cigarettes ◌ Yes ◌ No

Chewing Tobacco ◌ Yes ◌ No

Cigar ◌ Yes ◌ No

Do you use controlled substances? ◌ Yes ◌ No If yes

Women: Are you...

☐ Are you Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Due Date ◌ Yes ◌ No If yes

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Amoxicillin

Other? ◌ Yes ◌ No If yes

Do you have, or have you had, any of the following?

Acid Reflux ◌ Yes ◌ No	Congenital Heart Disease ◌ Yes ◌ No	Hepatitis C ◌ Yes ◌ No	Pain in Jaw Joints ◌ Yes ◌ No
ADD/ ADHD ◌ Yes ◌ No	Cortisone Medicine ◌ Yes ◌ No	High Blood Pressure ◌ Yes ◌ No	Parathyroid Disease ◌ Yes ◌ No
AIDS ◌ Yes ◌ No	Depression ◌ Yes ◌ No	High Cholesterol ◌ Yes ◌ No	Psychiatric Care ◌ Yes ◌ No
Alzheimer's Disease ◌ Yes ◌ No	Diabetes ◌ Yes ◌ No	Hiv Positive ◌ Yes ◌ No	Radiation Treatments ◌ Yes ◌ No
Anemia ◌ Yes ◌ No	Emphysema ◌ Yes ◌ No	Hypoglycemia ◌ Yes ◌ No	Renal Dialysis ◌ Yes ◌ No
Angina ◌ Yes ◌ No	Endocartitis ◌ Yes ◌ No	Irregular Heart Beat ◌ Yes ◌ No	Sickle Cell Disease ◌ Yes ◌ No
Arthritis ◌ Yes ◌ No	Epilepsy or Siezures ◌ Yes ◌ No	Kidney Problems ◌ Yes ◌ No	Sinus Trouble ◌ Yes ◌ No
Artificial Heart Valve ◌ Yes ◌ No	Excessive Bleeding ◌ Yes ◌ No	Leukemia ◌ Yes ◌ No	Sleep Apnea/ Cpap ◌ Yes ◌ No
Artifical Joint ◌ Yes ◌ No	Fainting Spells/ Dizziness ◌ Yes ◌ No	Liver Disorder ◌ Yes ◌ No	Stents ◌ Yes ◌ No
Asthma ◌ Yes ◌ No	Hay Fever ◌ Yes ◌ No	Low Blood Pressure ◌ Yes ◌ No	Stomach/ Intestinal Disorder ◌ Yes ◌ No
Anxiety ◌ Yes ◌ No	Heart Attack/ Failure ◌ Yes ◌ No	Lung Disorder ◌ Yes ◌ No	Stroke ◌ Yes ◌ No
Breathing Problems ◌ Yes ◌ No	Heart Murmur ◌ Yes ◌ No	Mitral Valve Prolapse ◌ Yes ◌ No	Thyroid Disorder ◌ Yes ◌ No
Bruise Easily ◌ Yes ◌ No	Heart Trouble/ Disease ◌ Yes ◌ No	MRSA ◌ Yes ◌ No	Tuberculosis ◌ Yes ◌ No
Cancer ◌ Yes ◌ No	Hemophilia ◌ Yes ◌ No	Osteoporosis ◌ Yes ◌ No	Tumors or Growth ◌ Yes ◌ No
Chemotherapy ◌ Yes ◌ No	Hepatitis A ◌ Yes ◌ No	Organ Transplant ◌ Yes ◌ No	Ulcers ◌ Yes ◌ No
Cold Sores/ Fever Blisters ◌ Yes ◌ No	Hepatitis B ◌ Yes ◌ No	Pacemaker ◌ Yes ◌ No	

Have you ever had any serious illness not listed ◌ Yes ◌ No If yes

Comments:

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:

X_____ Date:_____