Divine Dental

Dr. Rachel Mismas

We would like to get to know you better!

Patient Name: _____ Birthdate: ____/_____/_____ Today's Date: _____/_____/_____

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 questions.

Are you under a physician's care now?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Are you taking any medications, pills or drugs?	Yes	No
Do you take or have taken Phen-Fen or Redux?	Yes	No
Have you ever taken bone replacement medications such as Foxamax or Boniva?	Yes	No
Are you on a special diet?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances?	Yes	No

Women: Are you…

Pregnant Nursing Taking Oral Contraceptives?

Are you allergic to the following?

Aspirin Penicillin Codeine Acrylic
Metal Latex Sulfa Drugs Local Anesthetics

Other? If Yes, _____

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

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

Have you ever had any serious illness not listed above? Yes No

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 _____ Date: _____/_____/_____

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PATIENT Name: _____ Male ⬭ Female ⬭ Birthdate: ____/_____/_____

Address: _____ City: _____ State: _____ Zip code: _____

Cell Phone: _____ Home: _____ E-Mail: _____

SS #: _____-_____-_____ Occupation: _____ Employer: _____

If patient is a minor,

Parent's Name: _____ Parent's DOB: _____/_____/_____ SS #: _____-_____-_____

Parent's occupation: _____ Parent's employer: _____

Spouse's Name: _____ Spouse's DOB: _____/_____/_____ SS #: _____-_____-_____

Spouse's occupation: _____ Spouse's employer: _____

INSURANCE

Name of carrier: _____ Group #: _____ Phone #: _____

Name of Subscriber: _____

Name of additional carrier: _____ Group #: _____ Phone #: _____

Who referred you to our office: _____

Date of last dental visit: _____ Treatment performed: _____

Are you sensitive to:	Yes	No
Heat	⬭	⬭
Cold	⬭	⬭
Sweets	⬭	⬭
Biting Pressure	⬭	⬭
Does food get caught between teeth?	⬭	⬭
Do you have an unpleasant taste or odor?	⬭	⬭
Do your gums bleed while brushing?	⬭	⬭
Are you concerned about finances?	⬭	⬭
Have you ever had botox or facial fillers?	⬭	⬭
Are you dissatisfied with the appearance of your teeth?	⬭	⬭
If yes, explain:		
Do you have any fears of the dentist?	⬭	⬭
Are you having any areas of concern today?	⬭	⬭
If yes, explain: _____		

I Understand that I am responsible for payment of my account within 90 days after treatment

Patient Signature: _____ Date: _____/_____/_____