Dr. Rachel A. Mismas
Dr. Andrew C. Stutz
We would like to get to know you better

Name:_______________ Male ☐ Female ☐ Date:___________
Address: _______________ Zip Code:_______
Home Phone: ___________ Cell: ___________ E-Mail___________
If Child, Parent Name: ___________ Cell:___________ DOB:_______
SS #:___________ Occupation:___________ Employer:___________
Spouse's Name:___________ Spouse's DOB:___________ Spouse's SS#:___________
Spouse's Occupation:___________ Spouse's Employer:___________
Who Referred you to our office:___________
Date of last dental visit:___________ Treatment performed:___________

INSURANCE:

Name of Carrier:___________ Group #:___________ Phone #:___________
Name of Subscriber:___________
Name of Additional Carrier:___________ Group #:___________ Phone# __ _____
Name of Subscriber:___________

I understand that I am responsible for payment of my account within 90 days after treatment:_____

Are you teeth 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?	☐	☐
Jaw Problems:		
Clicking	☐	☐
Pain or Difficulty when Opening or Closing	☐	☐
Have you ever had reaction to local anesthetic?	☐	☐
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 smoke?	☐	☐
Have you had teeth removed? When?_______	☐	☐
Do you have any fears of the Dentist?	☐	☐
Are you having any areas of concern today?	☐	☐
If yes, explain:___________		

Patient Signature: ___________ Date:___________

MEDICAL HISTORY

Patient Name:____

*Are you currently under a physician's care? _____ If yes, please explain:____________________
Have you ever been hospitalized or had a major operation? ____ If yes, please explain:________________
Have you ever had a serious head or neck injury? ____ If yes, please explain:____________________
Are you taking any medications, pills, or drugs? ____ If yes, please explain:____________________
Do you take, or have you taken, Phen-Fen or Redux? _____ ____________________
Are you on a special diet? ____ Do you use controlled substances? ____
Are you: ____ Pregnant/Trying to get pregnant? ____ Nursing? ____ Taking oral contraceptives?
Do you take, or have you taken, Didronel___, Skelid ___, Fosamax____, Actonel ___, Boniva_____?
Are you allergic to any of the following?
___ Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____ Metal ____ Latex ____ Local Anesthetics
____ Other

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

____ Heart Ailment
____ Cold Sores
____ Hepatitis
____ Implants/Plastic Surgery
____ Asthma
____ Diabetes
____ HBP
____ Blood Disease
____ Epilepsy
____ Rheumatic Fever
____ Cancer/Radiation trx
____ Excessive Bleeding

*If yes, date last checked?____
Have you ever had any serious illness not listed above? ____ If yes, please explain:________________
____

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:__________________________ DATE:__________

HEALTH HISTORY UPDATE:

DATE:____________ CHANGES: ______________________________

SIGNATURE:______________________________

DATE:____________ CHANGES: ______________________________

SIGNATURE:______________________________

DATE:____________ CHANGES: ______________________________

SIGNATURE:______________________________

DATE:____________ CHANGES: ______________________________

SIGNATURE:______________________________