



946 East State Street
Mason City, Iowa 50401
641-424-4521

Welcome

Thank you for selecting our dental healthcare team. We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Today's Date: (month, day, year) _____

PATIENT INFORMATION Male Female

Patient's Name: (first, m.i., last) _____ Nickname: _____

Street Address: _____ Mailing Address: _____

City, State, Zip: _____

Birthdate: _____ Social Security #: _____

Telephone Numbers: Home (____) _____ Work (____) _____

Cell (____) _____ E-mail Address: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

If full time college student, name of school: _____ City, State: _____

Person responsible for this account

Self Employer: _____ Phone: (____) _____
Address: _____ City, State, Zip: _____

Spouse Name: _____ Phone: (____) _____
Address: _____ City, State, Zip: _____
Birthdate: _____ Social Security #: _____
Employer: _____ Phone: (____) _____
Address: _____ City, State, Zip: _____

Other Name: _____ Phone: (____) _____
Address: _____ City, State, Zip: _____
Birthdate: _____ Social Security #: _____
Employer: _____ Phone: (____) _____
Address: _____ City, State, Zip: _____

Referred by: _____ Relationship: _____

Do you have dental insurance: Yes No

PATIENT MEDICAL HISTORY

Patient's Name: _____

Physician: _____ Office Phone: _____ Date of last exam: _____

1. Are you undergoing medical treatment now? Yes No

2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

3. Are you taking any prescription medications? Yes No

If Yes, please list: _____

4. Are you taking any over-the-counter medications? Yes No

If Yes, please list: _____

5. Do you use tobacco? Yes No

6. Do you currently use or have you ever used recreational/illicit drugs? Yes No

7. Do you take or have you ever taken any of the following medications? (Check all that apply)

Fosamax Actonel Boniva Aredia (IV) Zometa (IV) Other bisphosphates

8. Do you have any of the following?

- | | | | | | |
|---------------------------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| Cardiac pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pains (Angina) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis (A, B, C or D) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart attack or heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS or HIV infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial heart valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart murmur or mitral valve prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seasonal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Low blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatic fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy/Convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fainting/Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding problem/Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually transmitted disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach troubles/ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leukemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Artificial Joint(s) Hip Knee Ankle Shoulder Other

Date(s) Placed: _____

9. Are you allergic to or have you had any reactions to the following

Local anesthetic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Penicillin or any other antibiotic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sulfa drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Iodine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Codeine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any Metals (i.e. nickel, mercury)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (Please list) _____		
Latex rubber	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		

10. Is there anything else we should know about your health? _____

11. Women Only

- | | | |
|---------------------------------------------------|------------------------------|-----------------------------|
| a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Are you nursing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Are you taking oral contraceptives? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PATIENT DENTAL HISTORY

- | | | |
|-----------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are your teeth sensitive to hot and cold liquids or foods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you had any difficult extractions in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you had braces or retainers? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you wear dentures or partials? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, approximate date of placement _____ | | |
| 7. Have you ever received oral hygiene instructions regarding the care of your teeth or gums? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Are you unhappy with the appearance of your teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information, and to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Information you give us is strictly confidential and will not be released to anyone without your permission.

Signature of Patient (or parent of minor)

(date)