946 East State St.reet
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?

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

Artificial Joint(s)	Hip	Knee	Ankle	Shoulder	Other
Date(s) Placed:	________	________	________	________	________

AHH-0411-2

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

Local anesthetic	☐ Yes	☐ No	Penicillin or any other antibiotic	☐ Yes	☐ No
Sulfa drugs	☐ Yes	☐ No	Iodine	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Any Metals (i.e. nickel, mercury)	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Other (Please list) ____________________		
Latex rubber	☐ Yes	☐ 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? ☐ Yes ☐ No
b) Are you nursing? ☐ Yes ☐ No
c) Are you taking oral contraceptives? ☐ Yes ☐ No

PATIENT DENTAL HISTORY

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