MONROE STREET FAMILY DENTAL

Adult Patient Form

Today's Date:

Patient Name: DOB: Gender: ☐ Male ☐ Female

Address: Main Contact Ph #:

Email Address: Alt Contact Ph #:

Emergency Contact *(name & phone #)*:

How did you hear about our office?

What can we do for you today?

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to complete the following information.

DENTAL HISTORY

Are you happy with your smile? ☐ Yes ☐ No

Are you teeth sensitive to the following? ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

Have you experienced pain or soreness in the muscles of your face? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Have you ever been treated for gum disease? ☐ Yes ☐ No

Are you concerned about the appearance or color of your teeth? ☐ Yes ☐ No

Are you apprehensive or nervous about dental treatment? ☐ Yes ☐ No

How long since you have seen a Dentist? Date of last complete dental exam:

Name of previous Dentist: City: State:

MEDICAL HISTORY

Please describe any current health problems.

Are you under a physician's care now? ☐ Yes ☐ No

If yes, please describe:

Family Physician: Ph #:

Check any of the following which you have had/or presently have:

- ☐ Heart Disease or Attack
- ☐ High Blood Pressure
- ☐ Heart Pacemaker
- ☐ Stroke
- ☐ Artificial Heart Valve
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Arthritis
- ☐ Rheumatic Fever
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Kidney Trouble
- ☐ Tumor Malignancy
- ☐ Radiation Treatment Conditions
- ☐ Chemotherapy
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Bleeding Problems
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ AIDS/HIV Positive
- ☐ Drug Addiction
- ☐ Hay Fever
- ☐ Thyroid Disease
- ☐ Nervousness
- ☐ Artificial Joints (hip, knee)
- ☐ Cortisone/Steroid Treatment
- ☐ Ulcers
- ☐ Psychiatric Treatment
- ☐ Tuberculosis (T.B.)
- ☐ Allergies or Hives
- ☐ Venereal Disease
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Asthma
- ☐ Epilepsy or Seizures
- ☐ Respiratory Problems

Please describe any marked above:

Are you allergic to or have you reacted adversely to any of the following?

☐ Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Nickel/other metals ☐ Nitrous Oxide ☐ Codeine
☐ Sulfa ☐ Penicillin ☐ Latex

Are you aware of being allergic to any other medications or substances? ..... ☐ Yes ☐ No
If yes, please list:

Do you have an pins or screws anywhere in your body? ..... ☐ Yes ☐ No
If yes, please list where:

What prescriptions or non-prescription medications are you currently taking? *(Please include herbal and recreational drugs)*

For Women: Are you pregnant, trying to get pregnant or on birth control? ..... ☐ Yes ☐ No

Do you Smoke? ☐ Yes ☐ No How long & how much?

Is there any other Medical or Dental information that you feel I should know about?

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

Your Signature: Date:

FINANCIAL POLICY

Payment is due when services are rendered. We accept cash, personal checks and all major credit cards. We realize that some procedures are more extensive than others and we are more than willing to work out alternative financial arrangements prior to treatment. I understand and agree that, (regardless of my insurance or marital status), I am ultimately responsible for the balance on this account for any professional services rendered.

I have read the above information and understand my obligations.

Signature of financially responsible party: Date: