102 E. Main Street – Norwalk, OH 44857 -- 419.663.0070

PATIENT DENTAL & MEDICAL HEALTH HISTORY INFORMATION

PATIENT INFORMATION	Last Name:	First Name:
Nickname:	SS No:	Email:
Home Phone:	Cell Phone:	Work Phone:
Married _____ Single _____ Divorced _____ Widowed _____ Separated _____		
Street Address:	City:	State/Zip:
Date of Birth:	Gender:	Occupation:
Emergency Contact:		Phone:
Family who are patients:		

INSURANCE INFORMATION	*We would like to copy your insurance card if you have one.
Policy Holder's Name:	
Policy Holder's Date of Birth:	
Policy Holder's SSN:	
Policy Holder's Employer/Title:	

DENTAL HISTORY & SYMPTONS	
What is the reason for your visit today?	
Are you currently experiencing any dental pain? Where?	
When was your last dental visit and what was done at that appointment?	

Have you ever had a serious injury to your head or mouth?	
Do you have earaches or neck pains?	
Do your gums bleed when you brush or floss your teeth?	
Have you ever had periodontal (gum) treatments like scaling and root planning?	
Do you have, or have you ever had, any sores or growths in your mouth?	
Have you ever had a reaction to , dental anesthesia?	
Are you unhappy with your smile? If yes... the color of your teeth, the shape of your teeth, the position of your teeth, other?	
Have you ever experienced any of these sleep-related breathing disorders? (Mouth breathing, snoring, trouble breathing during sleep)	

MEDICATIONS & OTHER PRODCUTS/SUBSTANCES	Yes	No
Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto), dabigatran (Pradaxa), heparin or aspirin)?		
Are you taking any medication to treat **osteoporosis** or Paget's disease? Some commonly-prescribed drugs include alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva) zolendronate (Reclast), and denosumab (Prolia).		
Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Some commonly-prescribed drugs include denosumab (Xgeva), pamidronate (Aredia) or zolendronate (Zometa)?		
Are you on **hormone replacement**?		
Do you use any form of **tobacco or nicotine products** (cigarettes, vapes, cigars, snuff, chew, bidis)?		
Do you take any other prescription and /or over-the-counter medicine(s), vitamins, herbs and/or supplements? Please provide a **SEPARATE LIST** – or write it on the back of this form.		
WOMEN ONLY: Are you taking birth control pills?		
WOMEN ONLY: Are your pregnant? If so, how long?		
WOMEN ONLY: Are your nursing? If so, how long?		

ALLERGIES	Yes	No
Aspirin?		
Codeine or other narcotics?		
Hay fever/ seasonal allergies?		
Iodine/shellfish?		
Local Anesthetics?		
Latex?		
Penicillin or other antibiotics?		
Sulfa Drugs?		
Other?		

MEDICAL & SURGICAL HISTORY	Yes	No
Date of last physical exam: / /		
What is your normal blood pressure (systolic, diastolic)?		
Doctor's name?		
Phone number?		
Are you in good physical health?		
Are you currently being seen or treated by a physician?		
Has a physician/previous dentist recommended you take antibiotics before having dental work done?		
Have you had a knee, hip or any joint replacement surgery?		
Have you had a serious illness, operation or been hospitalized in the past 5 years?		
Have you had a heart valve replacement or heart surgery?		
Have you had an organ or bone marrow/stem cell transplant?		
If you answered yes to any of the above, please explain:		

MEDICAL HISTORY SPECIFIC **(HEART CARDIAC HEALTH)**	Yes	No
Pacemaker/ implanted defibrillator?		
Artificial (prosthetic) heart valve?		
Previous infective endocarditis?		
Arteriosclerosis?		
Coronary artery disease?		

Congestive heart failure?		
Damaged heart valves?		
Heart attack?		
Heart murmur/ rhythm disorder?		
Rheumatic heart disease?		
Stroke?		

MEDICAL HISTORY SPECIFIC **(BREATHING RESPIRATORY HEALTH)**	Yes	No
Asthma (COPD)?		
Bronchitis?		
Emphysema?		
Sinus trouble?		
Tuberculosis?		

MEDICAL HISTORY SPECIFIC **(CANCER)**
Type:
Date of diagnosis:
Chemotherapy:
Radiation treatment:

MEDICAL HISTORY SPECIFIC **(BLOOD CIRCULATORY HEALTH)**	Yes	No
Anemia?		
Blood transfusion?		
Hemophilia?		
High or low blood pressure?		

MEDICAL HISTORY SPECIFIC **(BRAIN NEUROLOGICAL/MENTAL HEALTH)**	Yes	No
Anxiety?		
Depression?		
Epilepsy?		
Mental health disorders?		
Neurological disorders?		
Post – traumatic stress disorder?		
Traumatic brain injury or concussion?		

MEDICAL HISTORY SPECIFIC **(AUTOIMMUNE DISEASE)**	Yes	No
AIDS or HIV infection?		
Lupus?		

MEDICAL HISTORY SPECIFIC **(DIGESTIVE HEALTH)**	Yes	No
Gastrointestinal disease?		
G.E. reflux/persistent heartburn (GERD)?		
Stomach ulcers?		

MEDICAL HISTORY SPECIFIC **(OTHER)**	Yes	No
Arthritis?		
Chronic pain?		
Diabetes (type I or II)?		
Eating disorder?		

Frequent infections?		
Type of infection:		
Hepatitis, jaundice, or liver disease?		
Immune deficiency?		
Kidney problems?		
Malnutrition?		
Osteoporosis?		
Rheumatoid arthritis?		
Sexually transmitted infections (STI)?		
Thyroid problems?		

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM THAT NOT LISTED? IF SO, PLEASE EXPLAIN:

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor chooses and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written and signed financial arrangements have been made. **In the event of default, I promise to pay interest on the indebtedness and any and all costs associated with collection of the delinquent account.**

All amounts 90 days past due are assessed 1.5% interest per month on the unpaid balance.
_____ (initial)

As a courtesy to our valued patients, we will file claims for your insurance; **A SIGNED AND COMPLETED "SIGNATURE ON FILE FORM" IS REQUIRED FOR OUR FILES**. The responsibility of the insurance company is to you and it is your responsibility to see that you are reimbursed properly. Fees for services provided to insured patients are our usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage you were told by your insurance company or than the percentage listed in your benefit booklet. Stine Dental, LLC does not participate with any insurance companies in the fee schedules it has developed. In deciding whom they should participate with the doctors have selected YOU. We will do our very best to see that you receive all of the benefits due you.

SIGNED _____ **DATE** _____