New Country Dental Group

Confidential Medical and Dental History

Date: _____ Date of Birth: _____

Patient Name: _____ _____
Last First MI Prefer to be called

Gender: _____ □ Married □ Single □ Divorced □ Widowed □ Child □ Other_____

Social Security #: _____ Home Phone #: _____

Cell Phone #: _____ Work Phone#: _____

Address: _____
Street City State Zip Code

Employer Name:_____ Occupation: _____

Whom may we thank for referring you to our office? _____

In case of emergency, who should be notified? _____ Phone: _____

Dental Insurance:

Who is Responsible for this Account? _____ Relationship _____

Dental Insurance: _____ Group #: _____ Ins. ID: _____

Dental Insurance Address: _____

Secondary Dental Insurance: _____ Group #: _____ Ins. ID: _____

Dental Insurance Address: _____

Spouse Information: Name: _____ DOB: _____

Social Security #:_____

Employer Name & Address: _____

Medical History:

Physician's Name: _____ Phone: _____

Have you been hospitalized in the past two years? If yes, explain: _____

_____

Do you use tobacco products: □ Yes □ No How long? _____ How much? _____

Do you premedicate for dental appointments? □ Yes □ No If yes, explain: _____

Are you allergic or have you had an adverse reaction to any medication or latex? □ Yes □ No If yes please list: _____

Have you had any of the following? Please circle all that apply:

□ AIDS / HIV	□ Cancer	□ High Blood Pressure	□ Respiratory Issues
□ Alcohol Dependency	□ Chemotherapy	□ Kidney Disease	□ Sinus Problems
□ Anemia	□ Chemical Dependency	□ Liver Disease	□ Stomach Problems
□ Artificial Joints Year_____	□ Diabetes	□ Mental Disorder	□ Stroke
□ Artificial Heart Valve	□ Dizziness / Vertigo	□ Mitral Valve Prolapse	□ Thyroid Disease
□ Asthma	□ Emphysema	□ Nervous Disorder/ Anxiety	□ Tuberculosis
□ Autoimmune Disorder	□ Epilepsy	□ Nursing	□ Bisphosphonates (osteoporosis med) which? _____
□ Blood Disorder	□ Glaucoma	□ Pregnant Due Date_____	
□ Blood Thinners	□ Head Injury	□ Pacemaker	
	□ Heart Disease	□ Radiation Treatment	
	□ Hepatitis		

Do you have any condition not listed above? _____

Are you taking any medications? If yes, please explain. (please provide separate list if medications do not fit in allotted space): _____

_____

Dental History:

Purpose of this dental visit: _____

Date of last dental exam: _____ Date of last x-rays: _____

Are you nervous about having dental treatment? □ Yes □ No

Have you ever had a bad experience in a dental office? □ Yes □ No

If yes, please explain: _____

Have you ever had any complications following dental treatment: □ Yes □ No

If yes, please explain: _____

Do you feel like you have dry mouth? □ Yes □ No

Do you have trouble chewing? □ Yes □ No

Does food catch between your teeth? □ Yes □ No

Do you habitually clench or grind your teeth during the day or at night? □ Yes □ No

Have you ever been told you have gum problems? □ Yes □ No

Do you have bleeding gums or any other gum conditions? □ Yes □ No

Do you like the color of your teeth? □ Yes □ No

Do you have spaces you do not like? □ Yes □ No

Is there any old dental work that you do not like looking at? □ Yes □ No

What would you like to change the most in the appearance of your teeth if applicable?

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance. I will not hold the dentist or any member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form. I will notify the office of any changes that may occur in the future.

Signature: _____ Date:_____

I have reviewed my medical history and the above (including any changes) is accurate:

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Signature: _____ Date:_____

Records Release

Date: _____

Mailing Address: New Country Dental Group
5972 NY-31
Cicero, NY 13039

Phone: (315) 699-1100

Fax: (315) 699-4557

Email: info@newcountrydentalgroup.com

I authorize the release of the following dental records to New Country Dental Group.

Name: _____

Signature:_____

Previous Dentist Name: _____

Phone: _____

Fax: _____

Email: _____