MY CARE DENTAL

We Care for your smile ...

WELCOME TO MY CARE DENTAL! PLEASE COMPLETE ALL THE INFORMATION – THANK YOU

PATIENT LAST NAME:_____ PATIENT FIRST NAME: _____

DENTAL AND MEDICAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	❑	❑	Head, neck, jaw pain, or aches	❑	❑
Blisters on lips or mouth	❑	❑	Lip or cheek biting	❑	❑
Burning sensation on tongue	❑	❑	Loose teeth or broken fillings	❑	❑
Chew on one side of mouth	❑	❑	Mouth breathing	❑	❑
Cigarette, pipe, or cigar smoking	❑	❑	Orthodontic treatment	❑	❑
Smokeless tobacco	❑	❑	Nitrous Oxide	❑	❑
Dry mouth	❑	❑	Periodontal treatment	❑	❑
Food collection between teeth	❑	❑	Sensitivity to pressure or irritants	❑	❑
Clench or grind teeth	❑	❑	(cold, heat, sweets)		
Growths or sore spots in your mouth	❑	❑	How often do you floss? _____		
Gums swollen, tender or bleeding	❑	❑	How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ❑Yes ❑No

If Yes, please explain _____

Have you ever had trouble from previous dental care?

❑Yes ❑No If Yes, please explain _____

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

DENTAL & MEDICAL HEALTH HISTORY

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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for is answering the above questions

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be Dangerous to my (or Patient's) Health. It my responsibility to inform the dental office of any changes in medical status.

Signature of Patient OR Parent OR Guardian If Minor:_____**Date:**_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of My Care Dental notice of privacy practices is posted on the wall. By signing below, I acknowledge that I had an opportunity to review My Care Dental Notice of Privacy Practices. In this notice, I was advised of how health information about me may be used and disclosed by My Care Dental. I was also advised how I may obtain a copy of this information.

Signature of Patient OR Parent OR Guardian If Minor :_____ **Date:**_____

FINANCIAL CONSENT

Patients With Insurance:

I understand that My Care Dental, LLC will file dental claims on my behalf and I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I will promptly pay at the time of service or as determined by a payment plan agreement signed with my treatment plan.

Patients Without Insurance:

I understand I will be responsible for the costs of all treatment provided to me. I will pay at the time of service or as determined by a payment plan agreement signed with my treatment plan

If you have any questions please don't hesitate to ask. We are here to help you arrive at the treatment path that will best suit your needs.

Patient Name: _____**Person responsible for Finances:**_____

Signature of Patient or Person responsible for Finances or Parent or Guardian: _____**Date:** _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

- ☐ Another Patient (friend/relative)
- ☐ Dental Office
- ☐ Yellow Pages
- ☐ Newspaper
- ☐ School
- ☐ Work
- ☐ Other

Name of Person or Office referring you to our practice_____