

AINLEY FAMILY DENTAL CARE PATIENT MEDICAL HISTORY

Patient's Name:		Gender:	For Office Use Only ID: <input style="width: 50px;" type="text"/>
Address:		Today's Date:	Date of Last Visit:
City, State, Zip:		Email Address:	Date of Med. History:
Home Phone:	Work Phone:	Date of Birth:	Social Security No.:
Pharmacy:		Pharmacy Phone:	
Emergency Contact Name:		Relationship:	Phone:

INSURANCE INFORMATION

PRIMARY INSURANCE

Employee Name:	Employee Social Security Number:	Group Number:
Employer:	Insurance Company:	Insurance Company Phone:

SECONDARY INSURANCE

Employee Name:	Date of Birth:	Social Security No.:	Group Number:
Employer:	Insurance Company:	Insurance Company Phone:	

If female, please answer the following:

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If so, how many weeks? <input style="width: 50px;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?

Please answer the following:

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco? If so, how much per day? <input style="width: 50px;" type="text"/>
For Office Use Only:		Height: <input style="width: 50px;" type="text"/>
BP: <input style="width: 50px;" type="text"/>	Heart Rate: <input style="width: 50px;" type="text"/>	Weight: <input style="width: 50px;" type="text"/>

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center;">Y</td><td style="text-align: center;">N</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina Pectoris</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Bones</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blood Transfusion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer -Chemotherapy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Colitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Congenital Heart Defect</td></tr> </table>	Y	N		<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Cancer -Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<table border="1" style="width: 100%; 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Please List All Known Medications and Substances you have had an Adverse or Allergic Reaction to below:

Y N <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> Codeine <input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics	Y N <input type="checkbox"/> <input type="checkbox"/> Erythromycin <input type="checkbox"/> <input type="checkbox"/> Jewelry <input type="checkbox"/> <input type="checkbox"/> Latex	Y N <input type="checkbox"/> <input type="checkbox"/> Metals <input type="checkbox"/> <input type="checkbox"/> Penicillin <input type="checkbox"/> <input type="checkbox"/> Tetracycline	Other: _____ _____ _____ _____
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Please List All Prescribed and Over-the-Counter Medications you are currently taking:

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If there is any disease, condition, or problem that you think Dr. Ainley should know about, please describe below:

Additional Questions

Y N <input type="checkbox"/> <input type="checkbox"/> Are you a smoker? <input type="checkbox"/> <input type="checkbox"/> Do you ever experience bad breath? <input type="checkbox"/> <input type="checkbox"/> Do you have a concern about bad breath? <input type="checkbox"/> <input type="checkbox"/> Do you have a bad taste in your mouth? <input type="checkbox"/> <input type="checkbox"/> Are you having pain or discomfort at this time? <input type="checkbox"/> <input type="checkbox"/> Do you feel very nervous about having dental treatment? <input type="checkbox"/> <input type="checkbox"/> Have you ever had a bad experience in a dental office?	Y N <input type="checkbox"/> <input type="checkbox"/> Do you have problems with snoring? <input type="checkbox"/> <input type="checkbox"/> Are you pleased with your smile? <input type="checkbox"/> <input type="checkbox"/> Are you pleased with the color of your teeth? <input type="checkbox"/> <input type="checkbox"/> Are you pleased with the shape of your teeth? <input type="checkbox"/> <input type="checkbox"/> Are you pleased with the spaces between your teeth? <input type="checkbox"/> <input type="checkbox"/> Have you been a patient in a hospital in the past two years? <input type="checkbox"/> <input type="checkbox"/> Have you taken any medication or drugs in the past two years?
<input type="checkbox"/> <input type="checkbox"/> Have you been told that you need to premedicate with antibiotics for dental treatment? If yes, what medications and what dosages: <div style="background-color: #cccccc; height: 20px; width: 100%;"></div>	
<input type="checkbox"/> <input type="checkbox"/> Have you been under the care of a medical doctor during the past two years? Physician's Name: <input style="width: 300px;" type="text"/> Address: <input style="width: 300px;" type="text"/> Phone Number: <input style="width: 150px;" type="text"/>	

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____

The undersigned hereby authorizes Dr. Ainley and/or his staff to take x-rays, study models, photographs, or use any other diagnostic aids deemed appropriate by Dr. Ainley before, during, and after treatment, to make a thorough diagnosis of the patient's dental needs. I consent to their use in scientific papers and demonstrations, including my photograph being taken for the use in any and all office material. I also authorize Dr. Ainley to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Dr. Ainley choose and employ such assistance as deemed fit. I also understand that the use of anesthetic agents embodies a certain risk. I understand that payment for dental services provided in this office for myself or my dependents is my responsibility, due and payable at the time services are rendered. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required in collection of this note.

Patient Signature: _____ Date: _____ Witness: _____

Responsible Party: _____ Relationship to Patient: _____