AINLEY FAMILY DENTAL CARE PATIENT MEDICAL HISTORY

Patient's Name: | Gender: | For Office Use Only ID:

Address: | Today's Date: | Date of Last Visit: | Date of Med. History:

City, State, Zip: | Email Address:

Home Phone: | Work Phone: | Date of Birth: | Social Security No.: | Marital Status:

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	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If so, how many weeks?
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you use tobacco?	If so, how much per day?

For Office Use Only: BP: Heart Rate: Height: Weight:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Cosmetic Surgery	☐	☐	Hemophilia	☐	☐	Rheumatic Fever
☐	☐	Alcohol Abuse	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Difficulty Breathing	☐	☐	Hepatitis B	☐	☐	Shingles
☐	☐	Anemia	☐	☐	Drug Abuse	☐	☐	High Blood Pressure	☐	☐	Sickle Cell Disease
☐	☐	Angina Pectoris	☐	☐	Emphysema	☐	☐	HIV+ AIDS	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Kidney Problems	☐	☐	Stroke
☐	☐	Artificial Bones	☐	☐	Fainting Spells	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Artificial Heart Valve	☐	☐	Fever Blisters	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Frequent Headaches	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers
☐	☐	Blood Transfusion	☐	☐	Glaucoma	☐	☐	Pace Maker	☐	☐	Venereal Disease
☐	☐	Cancer -Chemotherapy	☐	☐	Hay Fever	☐	☐	Pneumocystitis	☐	☐	Yellow Jaundice
☐	☐	Colitis	☐	☐	Heart Attack	☐	☐	Psychiatric Problems			
☐	☐	Congenital Heart Defect	☐	☐	Heart Surgery	☐	☐	Radiation Therapy			

Please List All Known Medications and Substances you have had an Adverse or Allergic Reaction to below:

Y	N		Y	N		Y	N		Other:
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Metals	
☐	☐	Codeine	☐	☐	Jewelry	☐	☐	Penicillin	
☐	☐	Dental Anesthetics	☐	☐	Latex	☐	☐	Tetracycline	

Please List All Prescribed and Over-the-Counter Medications you are currently taking:

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

Additional Questions

Y	N		Y	N	
☐	☐	Are you a smoker?	☐	☐	Do you have problems with snoring?
☐	☐	Do you ever experience bad breath?	☐	☐	Are you pleased with your smile?
☐	☐	Do you have a concern about bad breath?	☐	☐	Are you pleased with the color of your teeth?
☐	☐	Do you have a bad taste in your mouth?	☐	☐	Are you pleased with the shape of your teeth?
☐	☐	Are you having pain or discomfort at this time?	☐	☐	Are you pleased with the spaces between your teeth?
☐	☐	Do you feel very nervous about having dental treatment?	☐	☐	Have you been a patient in a hospital in the past two years?
☐	☐	Have you ever had a bad experience in a dental office?	☐	☐	Have you taken any medication or drugs in the past two years?

☐ ☐ Have you been told that you need to premedicate with antibiotics for dental treatment?

If yes, what medications and what dosages:

☐ ☐ Have you been under the care of a medical doctor during the past two years?

Physician's Name: Address: Phone Number:

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:_____