Medical & Dental History

We are happy to have you join our great family of patients and friends.

The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve.

Please complete this form so that we can provide the best care possible for you.

Thank you!

Today's date: ____________

ABOUT YOU

Name: ____________________ ❑ Female ❑ Male

Nickname: ____________________

Address: ____________________

City: ____________________ State: ________ Zip: ____________

Home phone: ____________________ Bus. phone: ____________________

Cell phone: ____________________

Birth date: _____/_____/_____ Marital status: ❑ Single ❑ Married ❑ Widowed

E-mail address: ____________________

Name of spouse: ____________________

Names of children: ____________________

How do you enjoy spending your free time? ____________________

Who can we thank for referring you? ____________________

EMERGENCY INFORMATION

Person to contact: ____________________

Relationship: ____________________ Phone: ____________________

❑ I give permission for Boger Dental to share my medical and account information with:

____

DENTAL INSURANCE INFORMATION

Name of Primary Insurance Company: ____________________

Address: ____________________

Phone: ____________________

Name of policy holder: ____________________

Relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Policy holder's ID/social security #: ____________________ Group #: ____________

Policy holder's birth date: _____/_____/_____

Policy holder's employer: ____________________

Name of Secondary Insurance Company: ____________________

Address: ____________________

Phone: ____________________

Name of policy holder: ____________________

Relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Policy holder's ID/social security #: ____________________ Group #: ____________

Policy holder's birth date: _____/_____/_____

Policy holder's employer: ____________________

MEDICAL HISTORY

Patient Name: ______________________________ Birth Date: ______________ Date Created: ____________

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 answering the following questions.

Are you under a physician's care now?........................❏ yes ❏ no If yes, ______________________

Have you ever been hospitalized or had a ....❏ yes ❏ no If yes, ______________________
major operation?

Have you ever had a serious head or neck injury?........❏ yes ❏ no If yes, ______________________

Are you taking any medications, pills, or drugs? ....❏ yes ❏ no If yes, ______________________

Do you take, or have you taken, Phen-Fen or Redux?...❏ yes ❏ no If yes, ______________________

Have you ever taken Fosamax, Boniva, Actonel or
any other medications containing bisphosphonates?.......❏ yes ❏ no If yes, ______________________

Are you on a special diet?..........❏ yes ❏ no Do you use tobacco ....❏ yes ❏ no

Women: Are you: ❏ Pregnant/Trying to get pregnant? ❏ Nursing? ❏ Taking oral contraceptives?

Are you allergic to any of the following: ❏ Aspirin ❏ Penicillin ❏ Codeine ❏ Acrylic ❏ Metal ❏ Latex ❏ Sulfa Drugs
❏ Local Anesthetics ❏ Other ______________________

Do you use controlled substances? ....❏ yes ❏ no If yes, ______________________

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

AIDS/HIV Positive . . . .❏ yes ❏ no
Alzheimer's Disease . . . . . .❏ yes ❏ no
Anaphylaxis . . . .❏ yes ❏ no
Anemia . . . .❏ yes ❏ no
Angina . . . .❏ yes ❏ no
Arthritis/Gout . . . .❏ yes ❏ no
Artificial Heart Valve . . . . . .❏ yes ❏ no
Artificial Joint . . . .❏ yes ❏ no
Asthma . . . .❏ yes ❏ no
Blood Disease . . . .❏ yes ❏ no
Blood Transfusion . . . .❏ yes ❏ no
Breathing Problem . . . .❏ yes ❏ no
Bruise Easily . . . .❏ yes ❏ no
Cancer . . . .❏ yes ❏ no
Chemotherapy . . . .❏ yes ❏ no
Chest Pains . . . .❏ yes ❏ no
Cold Sores/Fever Blisters . . .❏ yes ❏ no
Congenital Heart Disorder . .❏ yes ❏ no
Convulsions . . . .❏ yes ❏ no
Cortisone Medicine . . . . . .❏ yes ❏ no
Diabetes . . . .❏ yes ❏ no
Drug Addiction . . . .❏ yes ❏ no
Easily Winded . . . .❏ yes ❏ no
Emphysema . . . .❏ yes ❏ no
Epilepsy or Seizures . . . . . .❏ yes ❏ no
Excessive Bleeding . . . .❏ yes ❏ no

Excessive Thirst . . . .❏ yes ❏ no
Fainting Spells/Dizziness . . .❏ yes ❏ no
Frequent Cough . . . .❏ yes ❏ no
Frequent Diarrhea . . . .❏ yes ❏ no
Frequent Headaches . . . . . .❏ yes ❏ no
Genital Herpes . . . .❏ yes ❏ no
Glaucoma . . . .❏ yes ❏ no
Hay Fever . . . .❏ yes ❏ no
Heart Attack/Failure . . . . . .❏ yes ❏ no
Heart Murmur . . . .❏ yes ❏ no
Heart Pace Maker . . . .❏ yes ❏ no
Heart Trouble/Disease . . . . .❏ yes ❏ no
Hemophilia . . . .❏ yes ❏ no
Hepatitis A . . . .❏ yes ❏ no
Hepatitis B or C . . . .❏ yes ❏ no
Herpes . . . .❏ yes ❏ no
High Blood Pressure . . . . . .❏ yes ❏ no
High Cholesterol . . . .❏ yes ❏ no
Hives or Rash . . . .❏ yes ❏ no
Hypoglycemia . . . .❏ yes ❏ no
Irregular Heartbeat . . . .❏ yes ❏ no
Kidney Problems . . . .❏ yes ❏ no
Leukemia . . . .❏ yes ❏ no
Liver Disease . . . .❏ yes ❏ no
Low Blood Pressure . . . . . .❏ yes ❏ no
Lung Disease . . . .❏ yes ❏ no

Mitral Valve Prolapse . . . . . .❏ yes ❏ no
Osteoporosis . . . .❏ yes ❏ no
Pain in Jaw Joints . . . .❏ yes ❏ no
Parathyroid Disease . . . . . .❏ yes ❏ no
Psychiatric Care . . . .❏ yes ❏ no
Radiation Treatments . . . . .❏ yes ❏ no
Recent Weight Loss . . . . . .❏ yes ❏ no
Renal Dialysis . . . .❏ yes ❏ no
Rheumatic Fever . . . .❏ yes ❏ no
Rheumatism . . . .❏ yes ❏ no
Scarlet Fever . . . .❏ yes ❏ no
Shingles . . . .❏ yes ❏ no
Sickle Cell Disease . . . .❏ yes ❏ no
Sinus Trouble . . . .❏ yes ❏ no
Spina Bifida . . . .❏ yes ❏ no
Stomach/Intestinal Disease . .❏ yes ❏ no
Stroke . . . .❏ yes ❏ no
Swelling of Limbs . . . .❏ yes ❏ no
Thyroid Disease . . . .❏ yes ❏ no
Tonsillitis . . . .❏ yes ❏ no
Tuberculosis . . . .❏ yes ❏ no
Tumors or Growths . . . .❏ yes ❏ no
Ulcers . . . .❏ yes ❏ no
Venereal Disease . . . .❏ yes ❏ no
Yellow Jaundice . . . .❏ yes ❏ no

Have you ever had any serious illness not listed?.........❏ yes ❏ no If yes, ______________________

Comments: ____

____

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 is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: ______________________________ Date: ______________

DENTAL HISTORY

On a scale of 1 to 5 (1 low/poor, 5 high/good) please rate:

How do you feel your overall dental health is: 1 2 3 4 5

Over the last ten years rate how faithfully have you had your teeth cleaned:..1 2 3 4 5

What is your level of sensitivity to dental procedures? 1 2 3 4 5

How do you feel about your smile and the look of your teeth: 1 2 3 4 5

Date of your last hygiene visit? _____/_____/_______

Are you interested in having regular hygiene cleanings? ❏ yes ❏ no

Have you ever been treated for gum disease? ❏ yes ❏ no When? ______________________________

What is the main reason for your visit today?

❏ Tooth pain ❏ I need a check-up ❏ Cleaning

❏ Orthodontics (braces) ❏ Whitening ❏ Cosmetic dentistry

❏ Sedation dentistry ❏ Other ______________________________

Have you ever been treated for TMJ? ❏ yes ❏ no

Have you ever or do you suffer from headaches? ❏ yes ❏ no

Tension headaches? ❏ yes ❏ no Migraine headaches? ❏ yes ❏ no

Muscle tenderness in jaw/teeth? ❏ yes ❏ no

I would like to learn more about:

❏ Orthodontics ❏ Whitening ❏ Cosmetic dentistry ❏ Sedation dentistry

❏ Implants ❏ Bridges ❏ Veneers ❏ Dentures

❏ Other ____

Is there any additional information that would be helpful in meeting your needs?

____

____

I ____, agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Boger Dental, PA. Initials:_________

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once will result in up to $100 charge and then discontinuation of services. Initials:_________

BOGER DENTAL

enhancing lives & smiles

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UPPER RIGHT

UPPER LEFT

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LOWER RIGHT

LOWER LEFT

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