PATIENT'S INFORMATION

ABOUT YOU:

MR. MRS. MS. NAME _____ _____
SOCIAL SECURITY NUMBER _____ - _____ - _____ DATE OF BIRTH _____-____-_____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE ( ) _____ - _____ CELLPHONE ( ) _____ - _____

EMPLOYMENT INFORMATION:
NAME OF EMPLOYER _____
BUSINESS ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
BUSINESS PHONE ( ) _____ - _____
PRESENT POSITION _____

ABOUT YOUR SPOUSE:

NAME _____
SOCIAL SECURITY NUMBER _____ - _____ - _____ DATE OF BIRTH _____-____-_____

EMPLOYMENT INFORMATION:
NAME OF EMPLOYER _____
BUSINESS ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
BUSINESS PHONE ( ) _____ - _____
PRESENT POSITION _____

WHO WILL PAY THIS ACCOUNT? _____
ADDRESS (IF DIFFERENT FROM YOURS) _____
PHONE _____ _____

INSURANCE:

IF YOU HAVE DENTAL INSURANCE **THROUGH YOUR EMPLOYER**, PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURANCE COMPANY _____
GROUP # _____ POLICY # _____

IF YOU ARE COVERED BY DENTAL INSURANCE **FROM YOUR SPOUSE OR PARENT**, PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP _____
SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH _____-_____-_____
NAME OF INSURANCE COMPANY _____
GROUP # _____ POLICY # _____
INSURED EMPLOYED BY _____

WHO MAY WE THANK FOR REFERRING YOU? _____

YOUR SIGNATURE _____ **DATE** _____

ADULT HEALTH HISTORY

Michael W. Winter D.D.S.

PATIENT NAME _____ REVISED 9/06

I. CIRCLE APPROPRIATE RESPONSE (LEAVE BLANK IF YOU DO NOT UNDERSTAND THE QUESTION):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years? Why?_____
4. Yes No Are you being treated by a physician now? For what? _____
5. Yes No Have you had problems with prior dental treatment? _____
6. Yes No Are you in pain now?
7. Yes No Are you satisfied with the appearance of your teeth?

II. DO YOU HAVE OR HAVE YOU had: **CIRCLE ALL WHICH APPLY:**

8. Yes No Chest pain?
9. Yes No Swollen ankles?
10. Yes No Shortness of breath?
11. Yes No Ringing in ears?
12. Yes No Headaches?
13. Yes No Fainting spells?
14. Yes No Taken Fen-Phen or Redux diet pills?
15. Yes No Mitral Valve Prolapse?
16. Yes No Rheumatic fever?
17. Yes No High blood pressure?
18. Yes No Seizures?
19. Yes No Excessive thirst?
20. Yes No Frequent urination?
21. Yes No Dry mouth?
22. Yes No Sinus problems?
23. Yes No Difficulty swallowing?
24. Yes No Skin diseases?
25. Yes No Anemia?
26. Yes No VD (syphilis or gonorrhea)?
27. Yes No Herpes?
28. Yes No Diabetes?
29. Yes No Psychiatric care?
30. Yes No Artificial joint?
31. Yes No Prosthetic heart valve?
32. Yes No Blood transfusion?
33. Yes No Surgeries?
34. Yes No Pacemaker?
35. Yes No Contact lenses?
36. Yes No Allergies to Latex (gloves)?
37. Yes No ALLERGIES: to drugs, food, medications

Please list: _____
_____
_____

38. Yes No Recent fever, weight loss?
39. Yes No Bleeding problems, bruise easily?
40. Yes No Diarrhea, constipation, blood in stools?
41. Yes No Frequent vomiting, nausea?
42. Yes No Difficulty urinating, blood in urine?
43. Yes No Heart disease, heart murmur or defects?
44. Yes No Eye diseases, blurred vision?
45. Yes No Heart attack, heart defects?
46. Yes No Stroke, hardening of arteries?
47. Yes No TB, emphysema, asthma, other lung diseases?
48. Yes No Persistent cough, coughing up blood?
49. Yes No Hepatitis, jaundice, other liver diseases?
50. Yes No Stomach problems, ulcers?
51. Yes No Radiation treatment, chemotheraphy?
52. Yes No Family history of diabetes, heart problems, tumors?
53. Yes No Tumors, cancer?
54. Yes No Arthritis, rheumatism, joint pain, stiffness?
55. Yes No Kidney, bladder disease?
56. Yes No Thyroid, adrenal disease?
57. Yes No AIDS or ARC?

III. ARE YOU TAKING:

58. Yes No Recreational drugs?
59. Yes No Tobacco in any form?
60. Yes No Bone-building medication (i.e.) Fosomax
61. Yes No Drugs, medications (incl. Aspirin)?

Please list: _____
_____
_____

IV. WOMEN ONLY:

62. Yes No Are you or could you be pregnant?
63. Yes No Are you nursing?

ALL PATIENTS:

64. Yes No Do you have or have you had any other diseases or medical problems **NOT** listed on this form? If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or my medication.

Patients Signature: _____ Date ___/___/___ Dr. signature _____

recall review:

Patients Signature: _____ Date ___/___/___ Dr. signature _____

Patients Signature: _____ Date ___/___/___ Dr. signature _____

Patients Signature: _____ Date ___/___/___ Dr. signature _____