Adult Pre-Clinical 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

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: ____________________________________

INSURANCE INFORMATION

Insurance company name: ____________________________________

Group#: ____________________________________

ID/Social Security#: ____________________________________

Employer: ____________________________________

If spouse is your policy holder:

Spouse's name: ____________________________________

Spouse's birth date: _____/_____/_____ Spouse's SS#: ________________

Spouse's employer: ____________________________________

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 Stephen P. Boger Dental, DDS, 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 a $50 charge and then discontinuation of services. Initials:_________

BOGER DENTAL
enhancing lives & smiles

2720 Annapolis Circle N., Suite A, Plymouth, MN 55441 **763-546-7707 phone** 763-546-7713 fax BogerDental.com

MEDICAL HISTORY

Name of personal physician: ______________________________

Address: ______________________________ Phone number: ______________

Approximate date of last visit: ______________ Current health condition: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you had any serious health problems in the last five years? ❑ yes ❑ no If yes, please explain: ______________

____

(For women) Are your currently pregnant? ❑ yes ❑ no If yes, how many months? ______________

Please list prescription medications: ______________________________

____

Please list vitamin/herbal supplements? ______________________________

____

Do you know your blood pressure? ❑ yes ❑ no (If yes, what is it?) ______________

Please check if you're allergic to any of the following:

- ❑ Local anesthetics
- ❑ Penicillin/other antibiotics
- ❑ Barbiturates, sedatives, sleeping pills
- ❑ Sulfa drugs
- ❑ Aspirin
- ❑ Shellfish, iodine or red wine
- ❑ Codeine/other narcotics
- ❑ Latex sensitivity
- ❑ Other______________

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

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain:______________________________

____

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). Initial: __________

The information I have given is true and accurate to the best of my knowledge.

Signature ______________________________ *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

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 ________________________________

____

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