REAL DENTISTRY℠
Real Choices for Real People

CHART NUMBER

MEDICAL HISTORY

PATIENT NAME: ______________________ **AGE**: ________ **DATE**: ______________

1. Are you pleased with the appearance of your smile? ☐ YES ☐ NO If NO, explain________________
2. When did you last visit a dentist? ______________ 3. When was your last cleaning? ______________
4. When was the last time you had x-rays taken? ______________ Are they available? ……………………☐ YES ☐ NO
5. What would you like to discuss with the dentist today?
   - ☐ Tooth Ache ☐ Oral Surgery ☐ Partials/Dentures ☐ Cosmetic Dentistry/Whitening
   - ☐ Gum Problem ☐ Routine check-up ☐ Removal of Wisdom Teeth ☐ Crowns / Bridges
   - ☐ Braces ☐ Second Opinion ☐ Replacing missing teeth☐ Other ______________
6. Does the patient experience any of the following with regards to the jaw area (TMJ)? …………………………☐ YES ☐ NO
   - ☐ Popping ☐ Clicking ☐ Locking ☐ Pain on Opening ☐ Other ______________
7. Does the patient have missing teeth? ☐ YES ☐ NO If YES, does the patient have an appliance? ……… ☐ YES ☐ NO
   What type? ______________ What year was it made? ______________ Is it comfortable? ... ☐ YES ☐ NO
8. Is patient in good health? If NO, explain ______________.......☐ YES ☐ NO
   ____
9. Physician's Name: ______________ Phone Number: ______________
   Is patient under a physician's care now? If YES, explain ______________....... .☐ YES ☐ NO
   ____
10. Is patient taking any medication, such as prescription, over the counter or birth control pills, at this time? ……..☐ YES ☐ NO
    If YES, list medications ______________
11. Is the patient pregnant? If YES, how many months? ______________......................... .☐ YES ☐ NO
12. Has patient taken any weight loss medication? (E.g. Redux, PhenFen) If YES, when? ______________......☐ YES ☐ NO
13. Has patient taken Bisphosphanates? (Zometa, Actenol, Fosamax)………………………………………...☐ YES ☐ NO
14. Has patient ever had a blood transfusion? ……………………………………………………………… ☐ YES ☐ NO
15. Does the patient smoke? ☐ YES ☐ NO Use tobacco? ☐ YES ☐ NO Use Recreational Drugs …… ☐ YES ☐ NO
16. Does the patient use alcohol? If YES, how often? ______________ ……………. ☐ YES ☐ NO
17. Has the patient ever had an allergic reaction to any of the following? …………………………………………☐ YES ☐ NO
    - ☐ Penicillin ☐ Codeine ☐ Sulfa drugs ☐ Local anesthetics ☐ Latex ☐ Other ______________
18. Has the patient ever had a skin reaction to metals or jewelry? Specify ______________……………………☐ YES ☐ NO
19. Has the patient ever had prolonged bleeding after an injury or extraction? ………………………………………☐ YES ☐ NO
20. Does the patient have a cardiac pacemaker or artificial heart valve? …………………………………………… ☐ YES ☐ NO
21. Is there any family history of diabetes, heart murmur/problems, tumors? ……………………………………… ☐ YES ☐ NO
    Specify______________ Relation to patient______________
22. Please **check each box**, yes or no, if the patient has or had any of the following conditions listed below. Please do not leave blank.

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Allergies	☐	☐	Anemia	☐	☐	Angina
☐	☐	Arthritis	☐	☐	Artificial Joints	☐	☐	Asthma	☐	☐	Bleeding Disorders
☐	☐	Cancer	☐	☐	Chemotherapy	☐	☐	Cold Sores	☐	☐	Diabetes
☐	☐	Dizzy Spells	☐	☐	Emphysema	☐	☐	Epilepsy	☐	☐	Emotional Disorder
☐	☐	Fainting	☐	☐	Fever Blisters	☐	☐	Glaucoma	☐	☐	Heart Attack
☐	☐	Heart Bypass	☐	☐	Heart Murmur	☐	☐	Heart Problems	☐	☐	Heart Surgeries
☐	☐	Hepatitis	☐	☐	High Blood Pressure	☐	☐	HIV positive	☐	☐	Immunosuppressed
☐	☐	Jaundice	☐	☐	Kidney Disease	☐	☐	Liver Problems	☐	☐	Low Blood Pressure
☐	☐	Lung Disease	☐	☐	Nervous/Mental Disorder	☐	☐	Psychiatric Treatment	☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever	☐	☐	Sinus Trouble	☐	☐	Stroke	☐	☐	Thyroid problems
☐	☐	Tuberculosis	☐	☐	Venereal Disease	☐	☐	Other ______________			

23. Has patient had any disease, serious illness/surgery, condition or problem not listed above. ☐ YES ☐ NO
    If YES, please explain ______________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

X______________ ______________ ______________
Patient/Parent/Guardian's **SIGNATURE** Patient/Parent/Guardian's **PRINTED** name Date
Health History Reviewed by: ______________(Doctor's signature) Date ______________
Comments: ______________

RECALL UPDATE:
There have been no changes in my health history.
Patient's Signature **X**______________ Date ________
Doctor's Signature ______________ Date ________
Comments: ______________

RECALL UPDATE:
There have been no changes in my health history.
Patient's Signature **X**______________ Date ________
Doctor's Signature ______________ Date ________
Comments: ______________

CHART NUMBER

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Date: ____________________

Chart #: __________________

I. Patient Information

Name: ____________________ Birth date: ____________ Sex: ☐ M ☐ F
Address : ____________________ City/State: ____________ Zip Code: ________
Home Phone: (____)__________ Work Phone: (____)__________ E-mail: ____________
Social Security #: ____________ Driver's License: ____________ State: ________
Employer's Name: ____________ Phone Number: (____)________ Married ___ Single___

II. Responsible Party

Name: ____________________ D.O.B. (mm/dd/yyyy) _____/_____/__________
Relationship to Patient: ____________________
Social Security #: ____________ Driver's Lic. #: ____________ State: ________
Employer's Name: ____________________ Phone Number: (____)__________
Employer's Address: ____
City/State: ____________ Zip Code: ____________
Name of Insurance Company: ____________ Phone Number (____)__________
Union/Local: ____________ Group Number: ____________
Occupation: ____________ Date of Hire: ____________

III. Secondary Insurance Information

Name: ____________________ D.O.B. (mm/dd/yyyy) _____/_____/__________
Relationship to Patient: ____________________
Social Security #: ____________ Driver's Lic. #: ____________ State: ________
Employer's Name: ____________________ Phone Number: (____)__________
Employer's Address: ____
City/State: ____________ Zip Code: ____________
Name of Insurance Company: ____________ Phone Number (____)__________
Union/Local: ____________ Group Number: ____________
Occupation: ____________ Date of Hire: ____________

IV. Getting to Know You and Your Family:

Whom may we thank for referring you to our office? ____________________
When were your last dental x-rays taken? ____________________
When was your last dental visit? ____________________
What treatment was performed? ____________________

V. Emergency Contact:

Name: ____________________ Telephone: (____)__________

As a condition of my treatment by this office, I understand that financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1⅝% per month (19.5% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Dr. Hercules Real or his associate, I agree to pay therefore the reasonable value of said services to the Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

REWRITE THIS STATEMENT ON THE LINE BELOW: **I have read and understand the above conditions of treatment and payment and agree to their content**.

____

____

X____________________ Date: ____________ Relationship to Patient: ____________
Signature of Patient/Parent/Responsible Party