Dr. Peter G. Denby, D.D.S.

MEDICAL HISTORY

FOR

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, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: Policy Holder Preferred Name:
Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Section 3

Release info to :

Primary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Peter G. Denby, DDS,PC
326 East 1st South St.
Carlinville, IL 62626

NAME:_____

Patient Occupation_____Employed By_____

Spouse's Occupation_____Employed By_____

Patient's Physician_____Referred By_____

AGE_____WEIGHT_____HEIGHT_____SINGLE_____MARRIED_____WIDOW_____

THE FOLLOWING IMPORTANT INFORMATION IS NEEDED TO HELP MAKE YOUR DIAGNOSES:
Reason for present visit:

1. Chief complaint_____
2. Duration of complaint_____
3. Last visit to dentist_____What was done_____
4. Date of last full dental x-ray?_____
5. In your opinion what is your general dental condition?_____
6. What would the loss of your teeth mean to you(denture)?_____
7. Are your teeth painful to: Heat?_____Cold?_____Sweets?_____Chewing?_____Touch?_____
8. Does food catch between teeth?_____Where?_____When?_____
9. Do your gums bleed?_____Where?_____When?_____
10. Do Tarter and Stain return quickly?_____Do Cavities develop quickly?_____
11. Are you conscious of bad taste?_____Bad Breath?_____
12. Do you have any sensation of feeling in your gums?_____
13. Have you had difficulty a dental extraction?_____
14. Have you had previous periodontal treatment?_____Give Details_____
15. Orthodontic treatment?_____When?_____
16. Satisfied with the way your teeth look?_____
17. Missing teeth?_____When lost?_____Why?_____
18. Replacements?_____Why not?_____
19. Patient evaluation of replacements_____

Patient Habit History: (answer yes or no)

1 Do you smoke?_____How much?_____

2 Do you clench or grind your teeth during the day?_____Night?_____

3 Do you awaken in the morning with the teeth together?_____With aches in the jaw joint?_____With aches in the face or temple?_____Numb feeling in teeth?_____

4 Are you conscious of any thrusting habits with your tongue?_____

5 Are you conscious of sore teeth?_____ Loose Teeth?_____High or rough fillings?_____

6 Rough teeth?_____Movement of teeth?_____

7 Do you have difficulty opening and closing the mouth?_____Pain?_____

8 Clicking?_____Popping?_____

9 When do you brush your teeth?_____How often in a day?_____

10 Direction of brushing?_____Do you floss?_____

11 Have you ever had instructions in a supervised plaque control program?_____

12 Have you ever had an extremely frightening experience with dentistry?_____

13 When?_____

14 Who was your former dentist?_____Reason for leaving?_____

15 Have I treated any of your friends or family?_____Who?_____

Comments:_____

As a condition of your treatment by this office 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 patients 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.

I understand when I provide a check as payment, I authorize you to use information from the check to make a one-time electronic fund transfer from my account or to process the payment as a check transaction. If payment is returned unpaid I authorize you to collect any and all fees associated with this transaction.

A service charge of 1.1/2 %per month (18% per annum) on the unpaid balance will be charged on all account exceeding 30 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 the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the times 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 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

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.

_____
Patient name

_____ DATE_____
Signature of patient, parent or guardian
Relationship to patient _____