RESET FORM

Dental Perfections, Inc.
Medical/Dental History

MEDICAL HISTORY

1) How would you rate your overall health?..... ◯ GOOD ◯ FAIR ◯ POOR
2) Date of last physical examination: _____
3) Are you currently under the care of a physician?..... ◯ YES ◯ NO
   If yes, for what condition(s)? _____
4) Physician information: _____
   NAME PHONE NUMBER
   _____
   ADDRESS CITY STATE ZIP
5) Have you had any serious illness, operations, or been hospitalized within the past 5 years?..... ◯ YES ◯ NO
   If yes, for what reason? _____
6) Have you had any cosmetic procedures or elective surgeries completed?..... ◯ YES ◯ NO
   If yes, please describe:_____
   Please provide us with the following information of the physician in charge of the procedure:
   _____
   NAME PHONE NUMBER ADDRESS CITY STATE ZIP
7) Have you had medical x-rays in the last 5 years? ..... ◯ YES ◯ NO
   If yes, please explain: _____
8) Are you taking any prescribed medications, over-the-counter medications, creams, supplements or herbs? If yes, **please list all**..... ◯ YES ◯ NO

	NAME	DOSE/FREQUENCY	REASON FOR TAKING
PRESCRIBED MEDICATIONS			
OVER THE COUNTER MEDICATIONS			
VITAMINS, NATURAL OR HERBAL PREPARATIONS, GRAPEFRUIT (FRUIT AND/OR JUICE), DIET SUPPLEMENTS			

9) Do you use tobacco products? ..... ◯ YES ◯ NO
   If yes, how interested are you in quitting? ◯ VERY ◯ SOMEWHAT ◯ NOT INTERESTED
10) Do you drink alcoholic beverages? ..... ◯ YES ◯ NO
    If yes, please list how many per week, e.g., 1-2 drinks/week: _____
11) Do you use recreational or street drugs? ..... ◯ YES ◯ NO
    If yes, how often? _____
12) Do you have any **allergies** (i.e., itching, rash, swelling of hands, eyes, or feet), or are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications?..... ◯ YES ◯ NO
    If yes, please list what you are allergic to and your reaction: _____
    _____
13) When you walk up stairs or take a walk, do you ever have to stop because of chest pain?..... ◯ YES ◯ NO
14) Do your ankles swell during the day?..... ◯ YES ◯ NO
15) Do you use more than 2 pillows to sleep?..... ◯ YES ◯ NO

Patient's Name: _____

16) Do you wake up short of breath?..... YES NO
17) Have you lost or gained more than 10 pounds in the last year? ..... YES NO
18) Are you on a special diet? ..... YES NO
19) Have you been told that you needed to be premedicated prior to any dental work?..... YES NO
If yes, for what reason? _____

Check any of the following **cardiovascular/heart conditions** you currently have or have had in the past:

☐ Angina	☐ Arteriosclerosis	☐ Artificial heart valves
☐ Chest pain upon exertion	☐ Congenital heart lesions/defects	☐ Congenital heart failure
☐ Coronary artery disease	☐ Damaged heart valves	☐ Heart attack
☐ Heart murmur	☐ Heart surgery	☐ High blood pressure
☐ Irregular heartbeat	☐ Low blood pressure	☐ Mitral valve prolapse
☐ Heart pacemaker	☐ Rheumatic heart disease/Rheumatic fever	☐ Scarlet fever
☐ Stroke	☐ Other (please specify): _____	
☐ NONE		

Check any of the following **respiratory conditions** you currently have or have had in the past:

☐ Asthma	☐ Bronchitis	☐ Emphysema
☐ Hay Fever	☐ Persistent cough or cough that produces blood	☐ Shortness of breath
☐ Sinus problems	☐ Tuberculosis (TB) ☐ Other (please specify): _____	
☐ NONE		

Check any of the following **blood disorders** you currently have or have had in the past:

☐ Abnormal bleeding	☐ Anemia	☐ Blood transfusion	☐ Bruise easily
☐ Hemophilia	☐ Excessive bleeding	☐ Leukemia	
☐ Sickle cell disease	☐ Other (please specify): _____		
☐ NONE			

Check any of the following **psychological conditions** you currently have or have had in the past:

☐ Anxiety	☐ Depression	☐ Psychiatric treatment	☐ Nervousness
☐ Other (please specify): _____			
☐ NONE			

Check any of the following **liver conditions** you currently have or have had in the past:
☐ Cirrhosis/liver disease ☐ Hepatitis ☐ Jaundice/yellow jaundice ☐ Other (please specify): _____
☐ NONE

Check any of the following health conditions you currently have or have had in the past:

☐ Allergies or hives	☐ Arthritis	☐ Artificial Joint	☐ Cancer
☐ Chemotherapy	☐ Cold sores/fever blisters	☐ Cortisone medication	☐ Drug addiction
☐ Epilepsy or seizures	☐ Diabetes	☐ Fainting or dizzy spells	☐ Glaucoma
☐ Herpes	☐ HIV antibody or AIDS	☐ Irritable bowel	☐ Kidney disease/dialysis
☐ Measles	☐ Mumps	☐ Radiation treatment	☐ Rheumatism
☐ Tumor	☐ Sexually transmitted disease	☐ Stomach problems	☐ Thyroid disease
☐ Ulcers	☐ Acid Reflux/GERD	☐ Gout	
☐ NONE			

For women.
1) Are you pregnant?..... YES NO
2) Are you looking to become pregnant?..... YES NO
3) Are you nursing?..... YES NO
4) Is there a chance that you could be pregnant? ..... YES NO

Please read and initial:
I understand it is my responsibility to inform the office if I am pregnant, looking to become pregnant, or nursing since it will affect my dental care and the scheduling of appointments. _____

5) Are you using a contraceptive?..... YES NO

Please read and initial:
I understand that taking antibiotics may render contraceptives ineffective. _____

Do you have any disease, condition, or problem that was not previously listed?..... YES NO
If yes, please describe here: _____

Patient's Name: _____

DENTAL NEEDS SURVEY

Date of your last dental appointment? _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
What type of oral hygiene tools do you use? _____
Do your gums bleed at any time?..... ◯ YES ◯ NO
Do you have aching or sensitive teeth?..... ◯ YES ◯ NO
Have you ever had an injury to your face or jaw?..... ◯ YES ◯ NO
Do you presently have or have you had *pain or discomfort* in the mouth, face, jaws or jaw joints (TMJs)?... ◯ YES ◯ NO
Have you had trouble associated with any previous dental treatment?..... ◯ YES ◯ NO

Please rank using numbers 1-5 the importance of each of the following regarding your dental care (the most important would be #1 and the least important would be #5):

_____ Preventive Dental Health Care
_____ Freedom From Pain
_____ Excellence & Quality of Service
_____ Cost & Affordability
_____ Other: _____

Please rank, as above, what a dentist has to do to gain your confidence:

_____ Show me what he/she is doing or needs to do so I can clearly understand what is happening.

_____ Listen to my concerns and explain thoroughly the procedures to be performed.

_____ Make sure I feel comfortable and informed at all times.

Please check the level of fear you have about your dental visits (10 being the greatest fear):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Are you concerned about the following (yes or no)?

_____ Existing discomfort?
_____ Whitening your teeth?
_____ Replacing old mercury silver fillings?
_____ Appearance of my smile?
_____ Recurring or untreated gum disease?
_____ Prevention of decay?
_____ Mouth odor?
_____ Other: _____

PLEASE CHECK ONE:

When discussing my treatment plan, I prefer:

◯ THE BIG PICTURE ◯ DETAIL BY DETAIL

When evaluating my smile, it's most important:

◯ WHAT I SEE ◯ WHAT OTHERS SEE

Do you have dental insurance? ◯ YES ◯ NO

If you did not have dental insurance, would you still have your dental care completed?

◯ YES ◯ NO

Patient's Name: _____

To the best of my knowledge, all of the preceding "Patient Information" and health history answers are true and correct. I also understand that it is my responsibility to inform the office of any changes to my medical history prior to **all** appointments.

_____ _____
Signature of Patient/Guardian/Patient Representative **Date**

Reviewed by: _____ _____
Signature of Doctor **Date**

GENERAL FINANCIAL/OFFICE POLICY

If you have dental insurance, we want you to receive the full benefit of it. Our office staff will assist you in completing your insurance forms and verifying the coverage that your particular insurance plan provides. We accept assignment of your insurance payment, another service to you. You are responsible for any applicable deductible amounts and the portion that your insurance does not cover. Please be advised that although our office will make every effort to accurately estimate what your insurance will pay, this ***does not, in any way,*** guarantee actual payment from your insurance company. You will be financially responsible for the account, should your insurance plan(s) not honor financial benefits for any procedure(s) rendered.

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with rendering appropriate dental care and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also give permission to Dental Perfections, Inc. to contact me at any and all contact numbers/emergency contact numbers/email addresses/mailing addresses provided as needed to determine appointments, account and/or insurance information, and any other information necessary for providing optimal patient care. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

I hereby attest that I have read the above section and understand it completely.

_____ _____
Signature of Patient/Guardian/Patient Representative **Date**