Medical History

116 North Locust Street
Momence, IL 60954
(815) 472-6345

www.ChingDDS.com

Patient Information

Date_____ Home Phone_____

Cell Phone_____ Soc. Sec._____-_____-_____

Name _____ Email _____
(Last) (First) (Middle Initial)

Address_____

City_____ State_____ Zip Code_____

Sex: ☐ Male ☐ Female Age_____ Birthdate_____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By_____ Occupation_____

Business Address_____ Business Phone_____

Whom May We Thank for Referring You? _____

In Case of Emergency Who Should be Notified? _____

Contact Phone # _____ Cell Phone _____

Who is responsible for this account? _____

Dental History for NEW Patients

Reason for Todays Visit_____ Date of Last Dental Care_____

Former Dentist_____ Date of Last Dental X-Rays_____

Check If You Have Had problems with any of the following:

☐ Bad Breath ☐ Grinding Teeth ☐ Sensitivity to hot/cold/sweets ☐ Bleeding Gums

☐ Loose teeth/Broken fillings ☐ Clicking/popping of jaw ☐ Periodontal Treatment

☐ Sensitivity when biting ☐ Food Collection between teeth ☐ Sores/Growths in mouth ☐ None Apply

How Often Do You Floss?_____ How Often Do You Brush?_____

Medical History

Primary Physician Name_____ Date of Last Visit_____

Address_____

Specialist Name_____Date of Last Visit_____

Address_____

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 medications that you are taking, could have an important interrelationship with the dentistry you will receive.

Have you ever had any serious illness/operations, been hospitalized ? Yes please describe & state when:

_____.

☐ No

Have you ever had a blood transfusion? ☐ Yes Date(s)_____ ☐ No

Have you ever had a serious head or neck injury? ☐ Yes please describe_____ ☐ No

Do you take, have you taken; Phen-Fed/ Redux, Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Do you use any controlled substances? ☐ Yes please describe_____. ☐ No

Are you on a special diet? ☐ Yes ☐ No

Women: Are you...

Pregnant/ Try to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No

Do you have, or have you had, any of the following? Please Circle YES or NO:

[Y] [N] AIDS/ HIV Positive	[Y] [N] Chest Pains	[Y] [N] Hepatitis A	[Y][N] Sinus Trouble
[Y] [N] Alzheimer's Disease	[Y] [N] Cold Sores/Fever Blisters	[Y] [N] Hepatitis B or C	[Y] [N] Stroke
[Y] [N] Anemia	[Y] [N] Cortisone Treatment	[Y] [N] Herpes	[Y] [N] Thyroid Disease
[Y] [N] Anaphylaxis	[Y] [N] Diabetes	[Y] [N] High Blood Pressure	[Y] [N] Tobacco Habit
[Y] [N] Arthritis/ Gout	[Y] [N] Drug Addiction	[Y] [N] High Cholesterol	[Y] [N] Tonsillitis
[Y] [N] Artificial Joints	[Y] [N] Epilepsy or Seizures	[Y] [N] Hypoglycemia	[Y] [N] Tuberculosis
[Y] [N] Asthma	[Y] [N] Emphysema	[Y] [N] Kidney Disease	[Y][N] Tumors/Growths
[Y] [N] Blood Disease	[Y] [N] Excessive Bleeding	[Y] [N] Leukemia	[Y] [N] Ulcers
[Y] [N] Blood Transfusion	[Y] [N] Excessive Thirst	[Y] [N] Mitral Valve Prolapse	
[Y] [N] Venereal Disease	[Y] [N] Breathing Problems	[Y] [N] Fainting/Dizziness	
[Y] [N] Respiratory Disease	[Y] [N] Vertigo	[Y] [N] Bruise Easily	
[Y] [N] Frequent Headaches	[Y] [N] Rheumatism	[Y] [N] Yellow Jaundice	[Y] [N] Cancer
[Y] [N] Glaucoma	[Y] [N] Scarlet Fever	[Y] [N] Chemotherapy	[Y] [N] Heart Murmur
[Y] [N] Shingles	[Y] [N] Heart Pacemaker	[Y] [N] Sickle Cell Disease	

Have you ever had any serious illness not listed above?

☐ Yes Please describe _____.

☐ No

Please List:

Any Medications you are currently taking:

_____

Do you need or have you ever needed premedication for dental procedures?

_____.

If Yes, What is your preferred pharmacy & its location?

_____.

Are you on any Blood Thinner?

_____.

Are you allergic to any of the following? Please check all that apply:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metals ☐ Latex ☐ Sulfa Drugs

☐ Local Anesthetics Please list any other allergies:_____

Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I have received this practice's Notice of Privacy Practices. I give my permission to Ching Dental and staff to take clinical records and/or photographs of my dental treatment for educational and instructional purposes. We ask you to show consideration by calling in advance if you are unable to keep an appointment as we would like to have the option to offer that appointment to another patient, kindly give a 24 hour Notice or a $50 cancellation fee will be billed directly to you.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

Payment is due in full at **time of treatment** unless prior arrangements have been approved