

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TOWN/STATE/ZIP \_\_\_\_\_

HOME TEL # ( ) \_\_\_\_\_ WORK TEL # ( ) \_\_\_\_\_ OTHER # ( ) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DENTAL INSURANCE CARRIER: \_\_\_\_\_ CONTRACT/I.D. # \_\_\_\_\_

CARRIER ADDRESS: \_\_\_\_\_ GROUP # \_\_\_\_\_

MEDICAL INSURANCE: \_\_\_\_\_ CONTRACT/I.D. # \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT: \_\_\_\_\_ PHONE # \_\_\_\_\_

SPOUSE: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK # \_\_\_\_\_

DENTAL INSURANCE CARRIER: \_\_\_\_\_ CONTRACT/I.D. # \_\_\_\_\_

CARRIER ADDRESS: \_\_\_\_\_ GROUP # \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_

PREFERRED DENTIST: \_\_\_\_\_ DR. SUTER \_\_\_\_\_ DR. LEVITT \_\_\_\_\_ DR. ZUGNER

**DENTAL HISTORY**

PREVIOUS DENTIST: \_\_\_\_\_ DATE OF LAST VISIT: \_\_\_\_\_

Have you had any serious problems associated with previous dental treatment ? \_\_\_\_\_

\_\_\_\_\_

Do you like the appearance of your teeth ? \_\_\_\_\_

How can we help you ? \_\_\_\_\_

\_\_\_\_\_

Do your gums bleed while brushing and/or flossing ? \_\_\_\_\_

Do you clench or grind your teeth ? \_\_\_\_\_

Do you experience frequent headaches ? \_\_\_\_\_

Does your jaw ever make noise, click, or hurt ? \_\_\_\_\_

Are you nervous or apprehensive about dental treatment ? \_\_\_\_\_

Have you ever had periodontal (gum) treatment ? \_\_\_\_\_

**I authorize Dr. Frederick H. Suter, Dr. Neal R. Levitt, or Dr. William E. Zugner to submit dental claims to my insurance carrier (if applicable) for dental services performed on me or my dependents in his practice.**

**If my account becomes delinquent, I understand I will be responsible for all costs, including finance charges, and all legal fees associated in retrieving payment in full.**

**The above information has been accurately completed by:**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print:** \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### MEDICAL HISTORY

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 may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Physician/Specialist's Name: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Are you currently under the care of a physician and/or specialist ? If so, for what reason ? \_\_\_\_\_

Please list ALL medications you take/are taking, including dosage, and for what reason: \_\_\_\_\_

#### HAVE YOU EVER BEEN TREATED FOR OR TOLD YOU HAVE:

	YES	NO		YES	NO
<b>Pre-medication required by physician</b>	_____	_____	Arthritis	_____	_____
<b>Mitral Valve Prolapse or Heart Murmur</b>	_____	_____	Kidney Problems/Dialysis	_____	_____
<b>Rheumatic Fever</b>	_____	_____	Ulcers	_____	_____
<b>Joint Replacement and/or Implant</b>	_____	_____	Immunity-related Diseases	_____	_____
<b>Pacemaker and/or Stent</b>	_____	_____	Asthma or other Lung Disorder	_____	_____
<b>Heart Problems</b>	_____	_____	Liver Disease	_____	_____
<b>Epilepsy and/or Seizures</b>	_____	_____	Tumor/Growth/Cyst	_____	_____
High Blood Pressure	_____	_____	Glaucoma	_____	_____
Cancer	_____	_____	Hepatitis (A, B, or C ?)	_____	_____
Diabetes (Type I or Type II ?)	_____	_____	Bleeding Problems	_____	_____
Tuberculosis	_____	_____	AIDS or HIV Infection	_____	_____
Fainting and/or Dizzy Spells	_____	_____	Eating Disorders	_____	_____

**Do you take/have you taken Coumadin, Warfarin, Heparin, or other blood thinner ?** \_\_\_\_\_

**Do you take/have you taken Fosamax, Boniva, Actonel, or other bisphosphonate ?** \_\_\_\_\_

Do you use any tobacco products ? \_\_\_\_\_

\* Please use the back of this page to inform us of any other health information you feel is important.

#### ARE YOU ALLERGIC OR SENSITIVE TO THE FOLLOWING:

Penicillin and/or other antibiotics	_____	_____	Aspirin	_____	_____
Codeine	_____	_____	Metals (e.g. nickel, mercury, etc.)	_____	_____
Latex	_____	_____	Other: _____		

#### WOMEN ONLY:

Are you pregnant ? \_\_\_\_\_  
Are you currently taking birth control pills ? \_\_\_\_\_

Are you nursing ? \_\_\_\_\_

**If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.**

**I have read this entire medical history, and have answered all questions accurately.**

Signature: \_\_\_\_\_