Misch Implant Dentistry

Specialists in Prosthodontics, Oral &
Maxillofacial Surgery and Dental Implants

PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # (_____)_____ Cell # (_____)_____

E-Mail address_____ Single ___ Married ___ Widowed ___

Date of Birth _____ Sex _____ Height _____ Weight _____

Occupation _____ Place of Employment _____

Spouse's Name _____ Spouse's Birth Date _____

Spouse's Employer _____

Closest Relative _____ Phone _____

If you are completing this form for another person, what is your relationship? _____

Did you visit our office website at *www.drmisch.com*? _____ Do you have a gmail account? _____

Who referred you to our office? Dr. _____ Friend _____ Ad _____

DENTAL INSURANCE INFORMATION

Insured's Name _____

Insured's Date of Birth _____

Dental Insurance Co. _____

Ins. Co. Address _____

_____

Insured's Employer _____

Insured's I.D. # _____

Group # _____

Dr. Misch does not participate in any dental insurance plans. If you have dental insurance we can help you fill out the necessary forms and information to assist you with a claim. Any payment from your insurance company will be directed to your mailing address.

DENTAL HISTORY

1. What is your chief complaint (reason for treatment)?_____

_____

_____

2. Date of your last dental exam _____ Dentist's Name _____
3. Are you in any discomfort or pain at this time?..... YES NO
4. Are you satisfied with the appearance of your teeth?..... YES NO
5. Are you able to eat and chew foods satisfactorily?..... YES NO
6. Do you have headaches, earaches or neck pain?..... YES NO
7. Have you ever had any problems associated with any previous dental care?..... YES NO

If yes, please explain

_____

_____

DENTAL HISTORY

Do you now have or have you had any of the following? Please indicate yes with an (x)

( ) Teeth sensitive to cold/hot/sweet	( ) Bad breath	( ) Use chewing gum
( ) Bleeding gums	( ) Unpleasant taste	( ) Difficulty opening jaw
( ) Food impaction	( ) Periodontal (gum) treatment	( ) Do you fear treatment
( ) Clenching or grinding	( ) Orthodontic treatment (braces)	( ) Do you brush daily
( ) Burning of tongue/mouth	( ) Endodontic treatment (root canal)	( ) Do you floss daily
( ) Swelling or lump in mouth	( ) Complications with extraction	( ) Do you use mouthwash
( ) Blisters on lips/mouth	( ) Smoke cigarettes, pipe, cigar, marijuana	( ) Fluoride supplements
( ) Clicking/popping of the jaw joint	( ) Use chewing tobacco	( ) Denture adhesive

MEDICAL HISTORY

In the following questions circle yes or no. Your answers are for our records only and will be considered confidential. THESE FACTS HAVE DIRECT BEARING ON YOUR DENTAL HEALTH.

1. Are you in good general health?..... YES NO
2. Has there been any change in your health within the past year?..... YES NO
3. Your last physical examination was on (approximate date) _____
4. Are you now under the care of a physician?..... YES NO

   If so, what is the condition(s) being treated?_____
5. The name, address and phone # of your physician_____

   _____

   Pharmacy Name _____ Phone # (_____)_____
6. Have you ever had any serious illness or operation?..... YES NO

   If so, please list illness/operation with date (year)_____

   _____
7. Have you been hospitalized or had a serious illness within the past five (5) years? YES NO

   If so, what was the problem?_____

   _____
8. Do you have or have you had any of the following diseases or problems?
   a. Congenital heart lesions, damaged heart valves, valve replacement..... YES NO
   b. Heart murmur..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary blockage, coronary stents, arteriosclerosis, bypass)..... YES NO
      1) Do you have pain in your chest upon exertion?..... YES NO
      2) Are you ever short of breath after mild exercise?..... YES NO
      3) Do your ankles swell?..... YES NO
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?..... YES NO
      5) Do you have a cardiac pacemaker?..... YES NO
   d. Stroke..... YES NO
   e. High blood pressure ..... YES NO
      Low blood pressure..... YES NO
   f. Allergies or hay fever..... YES NO
   g. Sinus trouble..... YES NO
   h. Asthma, bronchitis or emphysema (circle which one)..... YES NO

8. Do you have or have you had any of the following diseases or problems?

i. Hives or skin rash	YES	NO
j. Fainting spells or seizures	YES	NO
k. Diabetes	YES	NO
1) Do you have to urinate (pass water) more than six times a day?	YES	NO
2) Are you thirsty much of the time?	YES	NO
3) Does your mouth frequently become dry?	YES	NO
l. Hepatitis, jaundice or liver disease?	YES	NO
m. Arthritis	YES	NO
n. Inflammatory rheumatism (painful swollen joints)	YES	NO
o. Joint replacement	YES	NO
p. Stomach ulcers	YES	NO
q. Kidney trouble	YES	NO
r. Tuberculosis	YES	NO
s. Do you have a persistent cough or cold?	YES	NO
t. Frequent diarrhea or blood in your stools?	YES	NO
u. Immune deficient disease	YES	NO
v. Venereal disease (syphilis, gonorrhea, HPV)	YES	NO
w. Psychiatric treatment or emotional disturbance	YES	NO
x. Hyper or hypothyroidism	YES	NO
y. Osteoporosis	YES	NO
z. Cancer or malignancy	YES	NO
aa. Glaucoma	YES	NO
bb. Herpes, fever blisters, cold sores	YES	NO

cc. Other_____

9. Have you had abnormal bleeding associated with extractions, trauma or surgery?	YES	NO
a. Do you bruise easily?	YES	NO
b. Have you ever required a blood transfusion?	YES	NO

If so, explain the circumstances_____

10. Do you have any blood disorder such as anemia or sickle-cell?	YES	NO
11. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck?	YES	NO
12. Are you taking any drug or medicine?	YES	NO

If so, please list all:

_____

_____

_____

_____

13. Are you taking any of the following:

a. Antibiotics	YES	NO
b. Anticoagulants (blood thinners)	YES	NO
c. Medicine for high blood pressure	YES	NO
d. Cortisone or steroids	YES	NO
e. Sedative, tranquilizer	YES	NO
f. Antihistamines	YES	NO
g. Aspirin	YES	NO
h. Insulin or diabetes drug	YES	NO
I. Digitalis or drugs for heart trouble	YES	NO
j. Nitroglycerin	YES	NO
k. Oral contraceptive or other hormonal therapy (estrogen)	YES	NO
l. Osteoporosis drug – now or in the past (such as Zometa, Aredia, Fosamax, Actonel, Boniva, Reclast, Xgeva, Prolia)	YES	NO
m. Vitamins or other nutritional supplements	YES	NO

14. Are you allergic or have you reacted adversely to:
    a. Local anesthetics (lidocaine, novocaine)..... YES NO
    b. Penicillin or other antibiotics..... YES NO
       Allergy to what specific antibiotic(s)?_____
    c. Sulfa drugs..... YES NO
    d. Barbiturates, sedatives, or sleeping pills..... YES NO
    e. Aspirin or ibuprofen..... YES NO
    f. Iodine..... YES NO
    g. Codeine or other narcotics..... YES NO
    h. Latex ..... YES NO
    I. Adhesive tape (skin reaction)..... YES NO
    I. Other_____
15. Have you or a family member ever had an unusual reaction from being put to sleep for surgery?..... YES NO
16. Have you ever required unusually large amounts of local anesthetic for medical or dental treatment?..... YES NO
17. Do you have any disease, condition or problem not listed above that you think the doctor should know about?..... YES NO
    If so, please explain_____
    _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?..... YES NO
19. Are you wearing contact lenses?..... YES NO
20. Do you drink alcohol?..... YES NO
    If so, how much and how often_____
21. Do you smoke or use tobacco?..... YES NO
    If so, how much and how often?_____
22. Do you use or have you used recreational/street drugs?..... YES NO

WOMEN

23. Are you pregnant?..... YES NO
24. Do you have any problems associated with your menstrual period?..... YES NO
25. Are you nursing?..... YES NO

RESPONSIBILITY AND CONSENT FOR TREATMENT

I hereby authorize and request the performance of dental services for myself or for whom I am acting as legal guardian. I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named patient, regardless of insurance coverage.
To the best of my knowledge the information provided on this form is accurate and truthful.
If you had difficulty reading or understanding any of the questions, please make this known to the dentist.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Dentist Date