Mohave Dental Center
1406 Bailey Ave. Suite F
Needles, Calif. 92363

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name________________________________ Soc. Sec. #______________
Last Name *First Name* *Initial*

Address ________________________________

City ______________ State______ Zip__________ Home Phone ______________

Cell Phone ______________ Email ______________

Sex ❑ M ❑ F Age ________ Birthdate __________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by ______________ Occupation______________

Business Address ______________ Business Phone______________

Business Email ______________

Whom may we thank for referring you? ______________

Notify in case of emergency______________ Home Phone ______________

Cell Phone ______________ Business Phone ______________

Email______________

PRIMARY INSURANCE

Person Responsible for Account________________________________
Last Name *First Name* *Initial*

Relation to Patient______________ Birthdate______________ Soc. Sec. #______________

Address *(if different from patient)* ______________ Home Phone ______________

City______________ State__________ Zip ______________

Cell Phone______________ Email ______________

Person Responsible Employed by ______________ Occupation______________

Business Address ______________ Business Phone______________

Business Email ______________

Insurance Company ______________ Phone ______________

Insurance Email ______________

Contract #______________ Group #______________ Subscriber # ______________

Name of other dependents under this plan ______________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name______________ Relation to Patient ______________ Birthdate ______________

Address *(if different from patient)* ______________ Soc. Sec. #______________

City______________ State______ Zip__________ Home Phone ______________

Cell Phone______________ Email ______________

Subscriber Employed by ______________ Business Phone______________

Business Email______________

Insurance Company ______________ Phone ______________

Insurance Email ______________

Contract #______________ Group #______________ Subscriber # ______________

Name of other dependents under this plan ______________

Please complete both sides.

CONFIDENTIAL HEALTH HISTORY

Patient Name:______________________ Date of Birth:______________________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain ______________________
2. Yes No Has there been a change in your health within the last year?
   If YES, explain ______________________
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain ______________________
4. Yes No Are you being treated by a physician now? If YES, explain ______________________
   Date of last medical exam? ____________ Reason for exam ______________________
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain ______________________
   Date of last dental exam ____________ Name of last treating dentist ______________________
6. Yes No Are you in pain now?
   If YES, explain ______________________

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

PACE MAKER

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others: ______________________

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Please list: ______________________

VI. WOMEN ONLY

Yes No Are you or could you be pregnant?
If YES, what month? ____________

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ____________

Yes No Have you ever been pre-medicated for dental treatment? If YES, why ____________

Yes No Have you ever taken Fen-phen? If YES, when ____________

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ____________ Date: ____________

Physician's Name: ____________ Phone Number: ____________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

Please list all medications you are presently taking.

MEDICATION	DOSEAGE