Stephen G. Petinge, D.M.D.

Complete Esthetic Dentistry

MEDICAL HISTORY

Name: ____________________

Email: ____________________

Best contact # ____________________

Describe chief dental concern: ____________________

Please mark either:	Yes	No
Are you experiencing dental pain?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have any jaw pain?	☐	☐
Have you had a poor experience with dentistry?	☐	☐
Are you interested in saving your teeth?	☐	☐
Do your gums bleed when chewing or brushing?	☐	☐
Are you pleased with the appearance of your teeth?	☐	☐
Are you deeply concerned about the finances required to return your mouth to excellent dental health?	☐	☐

If you could change anything about your teeth, what would you change? ____________________

____

Are you currently taking, or have you ever taken, any bisphosphonates? ☐ ☐
If yes, for how long? ____________________

Are you under the care of a physician? ☐ ☐
Why? ____________________

____

List any medications, prescribed or self administered:

____

____

____

DOB: ____________________

Do you have or have you had any of the following:

	Yes	No
Mitral Valve Prolapse	☐	☐
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
Angina (chest pain)	☐	☐
Artificial Joint Replacement	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Stroke	☐	☐
Kidney Trouble	☐	☐
Arthritis	☐	☐
Diabetes	☐	☐
Tuberculosis	☐	☐
Malignancies (cancer)	☐	☐
AIDS or any related illness (HIV Virus)	☐	☐
Asthma or Emphysema	☐	☐
Productive Cough or Recent Cold	☐	☐
Hayfever, Allergies or Hives	☐	☐
Liver Disease, Jaundice, Hepatitis	☐	☐
Thyroid Disease	☐	☐
Epilepsy, Seizures, Convulsions	☐	☐
Difficulty in Hearing or Eye Disease	☐	☐
Psychiatric or Nervous Disorders	☐	☐
Do you smoke? If so how many packs per day ____		
Sinus Trouble	☐	☐
Excessive or Prolonged Bleeding	☐	☐
Anemia or Blood Disorder	☐	☐
Latex Allergy	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐

Do you have allergies to any Medications? ☐ ☐
List Medications you have allergies to:

____

____

Past Surgeries (last 5 years) ____________________

____

Pre Medication required by Physician? ☐ ☐

<u>WOMEN</u>

Are you taking medication for osteoporosis?	☐	☐
Pregnant? If so what month?	☐	☐
Are you taking birth control pills?	☐	☐

THE ABOVE MEDICAL HISTORY IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO ROUTINE PROCEDURES DEEMED NECESSARY FOR DIAGNOSIS AND TREATMENT.

Signature of Patient or Guardian ____________________ Date __________

Patterson #200096280

RESPONSIBLE PARTY INFORMATION

NAME Last ______________________ First ______________________ Middle Initial __________ MARITAL STATUS __________

RESIDENCE Street ______________________________ City ______________________ State ________ Zip ___________

MAILING ADDRESS Street ______________________________ City ______________________ State ________ Zip ___________

HOME PHONE ____________________ CELL PHONE ______________________ WORK PHON E ____________________

E-MAIL ADDRESS ______________________________________ SOCIAL SEC URITY# ___________________________

BIRTHDATE _______________ DRIVER'S LICENSE# ____________________ RELATION TO PATIENT ____________________

EMPLOYER _________________________ OCCUPATION _____________________ NO. YEARS EMPLOYED ___________

RESPONSIBLE PARTY'S SPOUSE

NAME ____

LAST FIRST MIDDLE

EMPLOYER ____ NO. YEARS EMPLOYED ________________

OCCUPATION ____ SOC. SEC.# ________________________

WORK PHONE ____ BIRTHDATE _________________________

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME ____

ADDRESS ____

CITY, STATE ____ PHONE ____________________________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ____

Insurance Co. ____

Insurance Co. Address ____

Insured's Employer ____

Insured's Soc. Sec# ____________________ Group# ____________________ Local # ____________________

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name ____

Insurance Co. ____

Insurance Co. Address ____

Insured's Employer ____

Insured's Soc. Sec# ____________________ Group# ____________________ Local # ____________________

***PLEASE READ AND SIGN THE FOLLOWING RESPONSIBILITY AND CONSENT STATEMENT:**

To the best of my knowledge, the above information is complete and correct. **I understand that I am responsible for any financial obligation incurred for the services provided.** I also authorize and request the performance of dental services for myself or my minor child and give my consent to any advisable and necessary dental procedures, medication, anesthetics or analgesics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. (You will be informed of planned services before services are rendered.)

DATE: ______________________ SIGNATURE: ____

(parent or guardian if patient is a minor)

Stephen G Petinge DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____

{Please Print Name}

____

{Signature}

____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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