1050 Larpenteur Ave. W.
St. Paul, MN 55113
(651) 488-5522
www.stpaulfamilydentistry.com

Patient Information

Today's Date ____

First Name | Middle Initial | Last Name ____

Date of Birth ______________ Social Security # ______________ Gender: Male | Female

Status: Child | Single | Married | Domestic Partnership | Other __________________

Home Address ____

City ___________________ State __________________ Zip Code ___________________

Home Phone # _____________ Cell Phone # _____________ Work Phone # _____________

E-mail Address ____

Emergency Contact Name and Phone # ____

Who is responsible for your account? ____

Name of Primary Dental Insurance Carrier ____

Subscriber Name _________________________________ Date of Birth ________________

ID # ___________________ Group # ___________________ Phone # __________________

Name of Secondary Dental Insurance Carrier ______________________________________

Subscriber Name _________________________________ Date of Birth ________________

ID # ___________________ Group # ___________________ Phone # __________________

Medical History For Patient:____

Are you under the care of a physician/MD? Yes | No

If yes, why? ____

Physician's Name and Phone #: ____

Please list the date of your last physical exam: ____

Are you in good health? Yes | No

Do you Snore and/or have you ever been diagnosed with sleep apnea?____________

If yes, what condition is being treated? ____

Has there been a change in your general health within the past year? Yes | No

If yes, what condition is being treated? ____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? Yes | No

If yes, what was the illness or problem? ____

Have you ever been pre-medicated for a dental visit? Yes | No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes | No

If yes, when was it performed? ____

If yes, have you had any complications? ____

Please list any prescription or over the counter medication you are currently taking and the dosage: ____

____

Do you use controlled substances (drugs)? Yes | No

Do you use tobacco? Yes | No

Do you drink alcoholic beverages? Yes | No

Are you taking, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (desphemfluramine) or phen-fen (fenflluramine-phentermine combination)? Yes | No

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? Yes | No

Were you ever treated or are you presently scheduled to begin treatment with the intravenous bisphosphanates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes | No

Please check any of the following, which you may have had or currently have:

__ Abnormal Bleeding
__ AIDS or HIV
__ Anemia
__ Angina
__ Arteriosclerosis
__ Arthritis/Gout
__ Artificial Heart Valve
__ Artificial Joints
__ Asthma
__ Autoimmune Disease
__ Blood Disorders
__ Blood Transfusion
__ Breathing Problems
__ Bronchitis
__ Cardiovascular disease
__ Cancer
__ Canker Sores
__ Chemical Dependency
__ Chemotherapy
__ Chest pain
__ Chronic Pain
__ Congenital Heart Defect
__ Coronary Artery Disease
__ Diabetes Type I or II
__ Damaged Heart Valves
__ Drug/Alcohol Addiction
__ Eating Disorder
__ Emphysema
__ Epilepsy/Seizures
__ Excessive Urination
__ Gastrointestinal Disease
__ G.E. Reflux/Heartburn
__ Glaucoma
__ Hay Fever
__ Headaches
__ Heart Attack/Failure
__ Heart Disease/Angina
__ Heart Murmur
__ Heart Transplant
__ Hepatitis A, B, C, D
__ Herpes
__ Hemophilia
__ High Blood Pressure
__ High Cholesterol
__ Infectious Endocarditic
__ Jaundice
__ Kidney or Liver Disease
__ Leukemia
__ Low Blood Pressure
__ Lung Disease
__ Malnutrition
__ Mental Health Disorder
__ Mitral Valve Prolapse
__ Neurological Disorders
__ Night Sweats
__ Osteoporosis
__ Pacemaker/ID
__ Radiation Treatments
__ Recent weight loss
__ Rheumatoid Arthritis
__ Rheumatic Fever
__ Rheumatic Heart Disease
__ Seasonal Allergies
__ Severe Weight Loss
__ Sleep Disorder
__ Sinus Problems
__ STD
__ Stroke
__ Swollen Glands
__ Systemic Lupus
__ Thyroid problems
__ Tobacco Use
__ Tuberculosis
__ Tumors/Growths
__ Ulcers

Are you allergic to or have you had a reaction to any of the following:

__ Animals
__ Aspirin
__ Barbiturates, sedatives, or sleeping pills
__ Codeine or other narcotics
__ Darvon
__ Demerol
__ Erythromycin
__ Food
__ Hay fever/seasonal
__ Iodine
__ Latex
__ Local anesthetics
__ Metals
__ Nitrous oxide
__ Novocain
__ Nuts
__ Penicillin
__ Percodan
__ Sulfa
__ Tetracycline
__ Valium
__ Vicodin
__ Other _______________
____
____

Dental History

Please indicate any of the following, which are of concern:

__ Bleeding Gums	__ Lip/Mouth Ulcers	__ Sensitivity when Chewing
__ Broken Tooth	__ Loose Teeth	__ Toothache
__ Brushing Habits	__ Mouth Odor	__ Other: _____________
__ Color/Shape of Teeth	__ Ear/Jaw/Neck Pain	_____________________
__ Dry Mouth	__ Sensitivity to Hot/Cold	_____________________
__ Flossing	__ Sensitivity to Sweets	

What is the reason for your visit today? ____

____

Who may we thank for your referral? ____

Women Only, are you:

Pregnant? ______________ Nursing? ______________ Taking Birth Control? _______________

I certify that I have read and understand the above and that all the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's Signature ____ Date_________________