MEDICAL HEALTH HISTORY PATIENT NAME: __________________________ Date:______________

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Welcome to our Practice!

PATIENT INFORMATION:

E-mail Address: _________________________________, Last Name:____________________________________ First Name: _________________________

Preferred to be called: _______________, Street Address:____

City, State, Zip: ____Date of Birth: _____________________________________

Cell Phone: _________________________________Work Phone: ______________________________________ Home Phone: __________________________

SS#: _________________________________, Driver's License: ____________________________________ Sex: __M F__ Occupation: _________________

Employer:____, Address, City State, Zip ____

Emergency Contact Name: ____ Phone # : __________________________________

Spouse's Name: ____Occupation: ____

Spouse's Address (if different than above): ____,City, State, Zip: _________________________

Spouse's Employer: ____ Address, City, State, Zip: ____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: ____**, Place**___________________________________ **Time:**____________

How did you hear about our office? Please check: _____Internet ____Patient referral ____Website ____Yellow Pages ___Mailer Other __________________

If you were referral whom may we thank for their trust in us? ____

INSURANCE INFORMATION:

Primary Insurance Company : ____ Address: ____

City: __________________________________ State: __________________ Zip: ____________________ Phone #: ____________________________________

Policy Holder Name: ____Member's ID# _____________________________ Birth date: ________________

Group# or Policy # ____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Dr. Michael P. Sedigh, DDS Inc. of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Patient's Signature: ____**Date:** _________________________________

MEDICATIONS:

Are you taking any medications including over the counter medications? If yes, please list:

1.	**5.**	**9.**
2.	**6.**	**10.**
3.	**7.**	**11.**
4.	**8.**	**12.**

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A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: ______________________________
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain:__________________________
4. Yes No Are you being treated by a physician now? For what? ____

Name of your physician: ____Date of last Medical Exam: ___________________

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Joint pain, stiffness
14. Yes No Jaundice
15. Yes No Dizziness
16. Yes No Ringing in ears
17. Yes No Frequent Headaches
18. Yes No Fainting spells
19. Yes No Blurred Vision
20. Yes No Seizures
21. Yes No Excessive thirst
22. Yes No Frequent urination
23. Yes No Dry Mouth
24. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

25. Yes No Heart disease
26. Yes No Heart attack, heart defects,
27. Yes No Heart murmur
28. Yes No Rheumatic fever
29. Yes No Stroke, hardening of arteries
30. Yes No High Blood Pressure
31. Yes No TB, emphysema or other lung diseases
32. Yes No Hepatitis, A B C
33. Yes No Stomach problems, ulcers
34. Yes No Diabetes
35. Yes No Mitral Valve Prolapse
36. Yes No HIV positive or AIDS-ARC
37. Yes No Tumors, Cancer
38. Yes No Arthritis, rheumatism
39. Yes No Eye disease
40. Yes No Skin disease
41. Yes No Anemia
42. Yes No VD (syphilis or gonorrhea)
43. Yes No Herpes
44. Yes No Kidney, bladder diseases
45. Yes No Thyroid, adrenal diseases
46. Yes No History of diabetes, heart problems, cancer

D. DO YOU HAVE OR HAVE YOU HAD:

47. Yes No Surgeries ______________________________
48. Yes No Blood Transfusions _____________________
49. Yes No Artificial Joint __________________________
50. Yes No Contact Lenses _________________________
51. Yes No Psychiatric Care ________________________
52. Yes No Currently Pregnant or nursing
53. Yes No Radiation Treatments
54. Yes No Chemotherapy
55. Yes No Prosthetic heart valve
56. Yes No Pacemaker
57. Yes No Currently taking Birth Control Pills

E. DO YOU TAKE OR HAVE TAKEN:

58. Yes No Recreational drugs
59. Yes No Alcohol
60. Yes No Tobacco in any forms
61. Yes No Phen Phen diet Pills or any other diet pills
62. Yes No Fosamax/Boniva or other osteoporosis (Bisphosphonate) drugs

F. ALLERGIES

Yes No Aspirin
Yes No Codeine
Yes No Dental Anesthetics
Yes No Erythromycin
Yes No Jewelry
Yes No Latex
Yes No Metals
Yes No Penicillin
Yes No Tetracycline

Other:____

Are taking any blood thinning medications such as Aspirin, Coumadin, Plavix etc?___________________________________

G. All Patient

63. Yes No Do you have any other diseases not listed on this form? If so, please explain:

____

64. Yes No Have you ever been told by a physician or dentist that you need to pre-medicate prior to any dental treatment?

____

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DENTAL HEALTH HISTORY

H. Name of your Former Dentist:_________________________________ How long since you were last seen?___________________

65. Is keeping your teeth important to you? [Yes] or [No] If yes. Why?____

66. On a scale 1-10, 10 being the best, where would you rate your smile? ____

67. On a scale 1-10, 10 being the best, where would you rate your oral health? ____

68. How many times a day/week do you brush & floss your teeth? Brush:_______ [Day] or [Week] Floss:_______ [Day] or [Week]

69. Have you experienced any of the following problems:

Bleeding gums [Y] [N]	Sensitivity to Hot & Cold [Y] [N]
Bad Breath or sour taste in mouth [Y] [N]	Snoring [Y] [N]
Burning sensations in mouth [Y] [N]	Food catching between teeth [Y] [N]
Soreness in jaw [Y] [N]	Clenching or Grinding of Teeth [Y] [N]
Is it hard for you to open wide? [Y] [N]	Pain/soreness around ears, eyes, face [Y] [N]
Clicking or popping in jaw [Y] [N]	Stiff neck muscles [Y] [N]
Have you or your parents suffer(ed) from Gum Disease? [Y] [N]	Do you or your parents wear dentures/partials? [Y] [N]
Did you ever wear braces? [Y] [N]	Ever been injured in your mouth or head? [Y] [N]
Oral Surgery of any kind? [Y] [N]	Do you smoke or chew tobacco? [Y] [N]

70. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? ________________________
____

71. Is the brightness of your teeth important to you? [Y] [N]

72. If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]	Close space or spaces [Y] [N]	Restore chipped teeth [Y] [N]
Replace missing teeth [Y] [N]	Replace old crowns [Y] [N]	Remove silver fillings [Y] [N]
Remove Stains/Spots on teeth [Y] [N]	Excess showing of Teeth [Y] [N]	Replace old plastic filling(s) [Y] [N]
Straighter Teeth [Y] [N]	Less Gum showing [Y] [N]	Reshape/resize my teeth [Y [N]

73. Fill in this question for us please: Together, what goals would you like for your oral health lifetime care?

74. Please circle the following which are important to you when making your dental health decision.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

Patient Signature: ____ Date:____________________