Andew J Reisterer, DDS, PLLC

Medical History

Date_____

Patient _____

Last name First Name Initial Preferred Name

Street Address_____City_____State_____Zip_____

E-mail Address_____Phone Number (Home)_____ (Cell)_____

Sex: __M __F Age_____ Birthdate_____ __Single __Married __Widowed __Separated _Divorced

Employed by_____Occupation_____

In case of emergency, who should be notified? _____ Phone (___)_____

Whom may we thank for referring you? _____

Physician's name and phone number? _____ Date of last Physical? _____

Have you ever had any of the following? (place an x next to those that apply):

__Heart problems
__High Blood Pressure
__Low Blood Pressure
__Circulatory Problems
__Nervous Problems
__Radiation Treatment
__Artificial Heart Valve
__Recent Weight Loss
__Back Problems
__Diabetes
__Respiratory Disease
__Epilepsy
__Headaches
__Hepatitis, Jaundice or Liver Disease
__Cancer
__Psychiatric Care
__Chronic Diarrhea
__Allergies to Anesthetics
__Allergies to Medicines or Drugs
__General Allergies
__Blood Diseases
__Arthritis
__Special Diet
__Swollen Neck Glands
__Rheumatic Fever
__Sinus Problems
__HIV/AIDS or Other
__Immunosupressive Disorders
__Stroke
__Ulcer
__Venereal Disease
__Chemical Dependency
__Hemophilia

Do you have any Drug Allergies, or have you ever had an adverse reaction to any medication_____? If so what?

_____

Are you taking any medications at this time? ___ If so, What?_____

Do you take or have you taken Phen-Fen or Redux? __yes __no

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing Bisphosphonates? __yes __no

Are you under the care of a physician? __yes __no For what conditions? _____

If patient is a child what is his/her weight? _____

(Women) Do you suspect that you are pregnant? __yes __no Are you nursing? __yes __no

Is there anything else we should know about your medical history?

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omission that I may have made in the completion of this form.

Date_____Signature_____

Dental History

What is the reason for your visit today? _____

Are you experiencing any dental pain or discomfort? __yes __no If yes, where? _____

When was your last dental exam, and what was done at the appointment? _____

When was the last time you had dental x-rays taken? _____

Please mark an "x" in the box if this applies to you.

Is it hard for you to open your mouth?
__yes __ no

Have you ever had periodontal (gum) treatment?
__yes __no

Serious injury to head or mouth?
__yes __no

Does it hurt to chew, bite or swallow?
__yes __no

Do you clench or grind your teeth?
__yes __no

Have you ever had problems with dental treatment? __yes __no

Do your gums bleed when you brush or floss? __yes__no

Does your jaw click, pop, or hurt?
__yes __no

Ever had a reaction to, or problem with dental anesthesia?
__yes __no

Are you happy with your smile? __yes__no

If no, why? Please mark all that apply:

The color of your teeth? __yes __no

The shape of your teeth? __yes __no

The position of your teeth? __yes __no

Other. Please describe: _____

STOP HERE! Do not sign below unless this is a Medical History update.

Medical History Update

Has there been any change in your health since your last dental appointment? __yes __no

For what conditions? _____

Are you taking any new medications? ___ If so, what _____

Date: _____ Patient Signature _____

Date: _____ Dentist Signature _____

Medical History Update

Has there been any change in your health since your last dental appointment? __yes __no

For what conditions? _____

Are you taking any new medications? ___ If so, what _____

Date: _____ Patient Signature _____