<18 years

"We Love Kids and Cowards"
John R. Loar, DDS & Associates

Date _____

Patient Name _____
Last First Middle Preferred Name

Date of Birth _____ Age___ Sex___ Home Phone_____ Other Ph._____

Address _____
Street City State Zip

Fathers Name _____
Last First Middle Address or **Same** Where Employed Bus. Phone

S.S. No._____ _____Father/ S.S. No. _____Mother/ S.S. No. _____ Patient

D.L. _____ Birthday__/____/__Father / D.L. _____ Birthday____/ __ / __ Mother

E-MAIL ADDRESS: _____ ❑Parent ❑Child

Mothers Name _____
Last First Middle Address or **Same** Where Employed Bus. Phone

Please tell us who referred you to our office? _____

Dental Insurance Information (Be sure all Information is Listed) *** Insured's DOB*** __/__/__
Insurance Co. Name Policyholder Policy or Certificate No.

1. _____
2. _____

Medical History B.P. _____/_____

1. Are you in good health? ❑ yes, ❑ no, ❑ don't know. _____; Height - _____ Weight - _____ lb.
2. Your Physician's Name _____ Address _____
   Are you under a physician's care now? ❑ no, ❑ yes -condition_____
3. List any Drugs, Herbs(over the counter or Prescription) being taken at this time(mg & times a day) ____
   _____
4. Please circle any illness you have ever had or taken; or Systems you have had problems with:

allergies	tuberculosis	anemia	kidney / or liver	diabetes
asthma	heart trouble	epilepsy	rheumatic fever	aids complex
hepatitis	herpes	venereal	high blood pressure	glaucoma
endocrine	respiratory	urinary	gastrointestinal	blood disorders
depression	neurologic	skeletal	dermal (skin)	cancer
taken Fosamax or other Bisphosphonates		osteoporosis	arthritis	other

5. Have you ever had trouble with prolonged bleeding after surgery? ❑ no, ❑ yes - _____
6. Have you ever been tested for HIV (AIDS Virus)? ❑ no, ❑ yes Results: Positive ❑ Negative ❑
7. Have you ever had any unusual reaction to anesthetic or drugs like penicillin, codeine, aspirin, iodine, or others? ❑ no ❑ yes - list _____
8. Have you ever been told by your Physician to take antibiotic pre-medication before dental treatment because of previous illness, joint replacement, mitral valve prolapse, taken Fen-Phen or Redux, or other medical treatment to prevent systemic bacteremia or SBE. ❑ no, ❑ yes - specific condition _____
9. Have you been Hospitalized in the last 15 years? ___ ; any blood transfusions ❑ no ❑ yes ; or is there any other information that should be known about your health?
   _____

For Females Only- if reached maturity:
1. Are you pregnant? ❑ no, ❑ yes - trimester 1 2 3
2. Are you nursing? ❑ no, ❑ yes _____
3. Are you taking birth control pills? ❑ no, ❑ yes Name

MEDICAL UPDATE - REVIEW

Date	Signature of Patient, Parent or Responsible Party - comments	Initials Asst/Hyg/ofMg/Dr
1. _____	_____	_____
2. _____	_____	
3. _____	_____	

****OVER or next page - 1 of 2 ****

DENTAL HEALTH HISTORY - Page 2

DATE OF LAST DENTAL EXAM ____________

1. What concerns you the most, or reason for the dental visit? ____________________

____

2. Do you have pain in your teeth because of heat, cold, or sweets? ☐ no, ☐ yes - If so, where ________

____

3. Do you have pain in any part of the mouth or in any tooth while biting or chewing? ☐ no, ☐ yes - where

____

4. Does food catch between your teeth? ☐ no, ☐ yes - where ____________________

5. Do your gums bleed, either in chewing or brushing or at any other time? ☐ no, ☐ yes - when and where

____

6. Do you clench your teeth during the day? ____________________

Have you been made aware of clenching your teeth during the night? ____________________

7. Do you use a stiff ☐, or soft ☐ bristled brush. How often do you brush a day? ____________

Do you avoid any part of your mouth while brushing? ____________________

8. Do your gums feel irritated, tender or swollen? ____________________

9. Are you completely **happy with the appearance** of your teeth? ☐ yes, ☐ no - why not? __________

10. Do you have all your teeth (other than wisdom teeth)? ☐ yes, ☐ no. ____________

11. If not, did you have missing teeth replaced? ☐ yes, ☐ no. ____________

12. Were you told why missing teeth should be replaced? ☐ yes, ☐ no, ☐ n/a

13. Do you lose fillings or break silver fillings? ☐ yes, ☐ no, ☐ n/a

14. Please circle, give dates, and record results if you have ever had; or Circle if you need:

Orthodontic treatment (braces) ________ Your teeth ground or bite adjusted __________

Oral Surgery ____________________ Worn a bite plate or other appliance __________

Gum treatments or gum surgery __________ Bleaching ____________________

15. Do you feel Dentures are inevitable? If older -late teens ☐ yes, ☐ no. ____________

16. How often do you have calculus (tartar) removed? (Professional teeth cleaning) Every ______ months.

17. Do you want to keep your teeth as long as possible? ☐ yes, ☐ no. ____________

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services. I authorize the use of slide pictures and/or diagnostic models to be used for professional presentations. I also authorize Dr. Loar/Associates to use anesthetics and medications deemed necessary during my dental treatment and I have been encouraged to ask questions if they should arise about any medication or procedure before or during any Dental treatment. The policy of our office is the parent who requests treatment for the child is responsible for all fees for services rendered. I have received or downloaded a copy of this office's Notice of Privacy Practices Practices (HIPAA).

____________ X____________________ ____________

Date (today) Signature of Patient, Parent or Responsible Party Asst/Hyg/OMg/Dr