PATIENT MEDICAL HISTORY

Patient's Name

Date of Birth:

Although Dental Personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the Dentistry that you will be receiving. Thank you answering the following question

general health within the past year? 12. Have you ever taken Fen-Phen/Redux? 13. Do you use tobacco? 13. Do you use tobacco? 14. Do you use tobacco? 14. Do you used/abused controlled substances? 15. Are you under the care of a physician? 15. Are you used/abused controlled 5. Are you under the care of a physician? 15. Are you used/abused controlled 5. Are you under the care of a physician? 15. Are you used/abused controlled 5. Are you taking any medicine(s) including non-prescription? 15. Do you have a persistent cough or throat 1. Are you taking any medicine(s) including non-prescription? 17. Do you have any disease, condition or 16. Do you bruise easily? 17. Do you have any disease, condition or 17. Do you bruise easily? 17. Do you have any disease, condition or 18. Have you taking birth control pills? Are you ursing? 19. Do you bruise easily? WOMEN ONLY: 10. Jour or other antibiotics? Are you ating birth control pills? 10. Lace Anesthetics (i.e. novocaine)? Hives or skin rash? 10. Jour Are to thave tyou EVER HAD THE FOLLOWING? Fainting or diazy spells? 10. Jour Have YOU EVER HAD THE FOLLOWING? Nomach Ulcer No UHAVE OR HAVE YOU EVER HAD THE FOLLOWING? Sexually Transmitted Disease </th <th>for answering the following questions.</th> <th></th> <th>-</th> <th>-</th>	for answering the following questions.		-	-
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Chest Pain Glaucoma				
Shortness of Breath Nervousness				
Pacemaker Tonsillitis				
Heart Surgery Tumors				
High Blood Pressure Mental Health Care				
Low Blood Pressure Back Problems	-			
Congenital Heart Problem Chemical Dependency				
Swelling of feet and ankles Mitral Valve Prolapse	-	· ·		
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		Lating Disorders		

DO YOU NOW, OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING? NO _____ If yes please check : Boniva Fosamax Actonel Zoneta Reclast IV Biophosphnates

PATIENT DENTAL HISTORY

Patient Name:	Date of Birth:		
Reason for this visit?			
When was your last dental visit? What was done at	What was done at that visit?		
Previous Dentist (Name and Location):			
How often do you brush your teeth?	How often do you floss your teeth?		
Is your drinking water fluoridated? When/where were your last	When/where were your last dental x-rays taken?		
YES N	NO YES NO		
Do your gums bleed while brushing or flossing?	Do you bite your lips or cheeks frequently?		
Are your teeth sensitive to hot or cold liquids or foods?	Are any of your teeth loose?		
Are your teeth sensitive to sweet or sour liquids or foods?	Does food tend to become caught between your teeth?		
Do you feel pain in any of your teeth?	Have you had periodontal (gum) treatment?		
Do you have any sores or lumps in or near your mouth?	Have you ever worn a bite plate or appliance?		
Have you had any head, neck or jaw injuries?	Have you had any difficult extractions?		
Have you ever experienced any of the following problems in your jaw?:	Have you had any prolonged bleeding after ext's?		
Clicking Pain (joint, ear, side of face) Difficulty opening or closing Difficulty chewing	Do you wear dentures or partials? If yes, date of placement:		
Do you have frequent headaches?	Have you ever received oral hygiene instructions?		
Do you clench or grind your teeth?			

If you could change anything about your smile, what would you change?_____

Authorization and Release

I certify that I have read and answered the above information to the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Koebley to release any information used for the diagnosis and treatment or examination rendered to me or my child during the periods of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Kevin B. Koebley, D.D.S., P.A., insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents within 30 days of treatment.

Signature	of resi	ponsible	party.
Signation	01100	001101010	per ej.

_____ Date: _____