*Thomas F. Mahar, D.D.S.* Email:

# Patient History

Date:______________

Patient: ______________________ Age:________ Birth date: ____________ ❑ Male ❑ Fe-male

Address: ______________________ City:______________ State:______ Zip:________

Social Security #: ______________________ Home Phone #:______________

Employer: ______________________ Work Phone #:______________

Employer's Address: ______________________

Spouse: ______________________ Birth date:______________

Address (if different):______________ Social Security #: ______________

Employer & Address:______________________ Phone: ______________

Person responsible for Dental Investment:______________ Relationship to patient: ______________

Address (if different):______________________

Social Security # of Insured Person: ______________________ Birth date:______________

Employer & Address:______________________ Phone: ______________

Name of Insurance Co. ______________________ Address: ______________

Name of Secondary Insurance Co. ______________ Address: ______________

In case of emergency who should we contact?______________________

Name & phone number of the nearest relative? ______________________

Who referred you to our office: ______________________

***Please check those that apply to you only.***

# Medical History

Your medical doctor's name:______________Location:______________Phone: ______________

How would you describe your present health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

| Please check yes or no to the following questions: | Yes | No |
|---|---|---|
| Have you been a patient in a hospital during the past two years? | ❑ | ❑ |

If so, purpose of stay? ______________________

| | | |
|---|---|---|
| Do you take any kind of medicines or blood thinners? | ❑ | ❑ |

If yes, please explain: ______________________

| | | |
|---|---|---|
| Are you allergic to penicillin or any other medicines or drugs? | ❑ | ❑ |

If yes:______________________

Do you have any food allergies? ______________________

Are you aware of needing any PreMedication or antibiotic prior to dental treatment? ______________

| | | | |
|---|---|---|---|
| ____High Blood Pressure | ____Diabetes | ____Hiatal Hernia | ____Mitral Valve Prolapse |
| ____Low Blood Pressure | ____Kidney Problems | ____Stroke | ____Sinus Problems |
| ____Heart Problems | ____Asthma | ____Cancer History | ____TMJ Problems |
| ____Rheumatic Fever | ____Emphysema | ____Steroid Use History | ____Smoker |
| ____Heart Murmur | ____Bleeding Disorder | ____Arthritis | ____HIV Positive |
| ____Hepatitis | ____Seizure Disorder | ____Prosthesis Joint | ____Thyroid Problems |

Women: Taking Birth Control pills?______________ Are you Pregnant?______________

Name ______________

Date ______________

What is your present problem?

______________________________________________

When was your last dental appointment?

______________________________________________

______________________________________________

| Are your teeth sensitive to: | YES | NO | |
|---|---|---|---|
| Heat, Cold, Sweets, Biting Pressure? | ❑ | ❑ | ________ |
| Do your gums bleed when brushing? | ❑ | ❑ | ________ |
| Have you noticed any gum swelling around any teeth? | ❑ | ❑ | ________ |
| Have you ever considered brightening your smile? | ❑ | ❑ | ________ |
| If you could have the perfect smile, how would you describe it? | ❑ | ❑ | ________ |
| Is there anything that would prevent you from receiving the treatment you would like? | ❑ | ❑ | ________ |
| Do you grind or clench your teeth? | ❑ | ❑ | ________ |
| Have you been diagnosed with sleep apnea? | ❑ | ❑ | ________ |
| Do you snore? | ❑ | ❑ | ________ |
| Do you have an unpleasant taste or odor in your mouth? | ❑ | ❑ | ________ |
| Have you ever had any teeth removed? | ❑ | ❑ | ________ |

How long have these teeth been missing? ______________________________

Do you have any dentures? ❑ Partials ❑ Crowns ❑ Implants

How old are they? ______________________________

I understand and agree that, (regardless of my insurance status). I am ultimately responsible for the balance of my account for any professional services rendered. In the event this account becomes past due and is turned over for collection, I agree to pay a $50 filing fee, attorney fees, collection fees, and court cost, if necessary. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient or Guardian Signature______________________________ Date______________

(Payment Plans are available if needed for extensive treatments.)

Name

Date