MEDICAL HISTORY **Patient name:** _____ **Date:** _____

1. If there was a simple inexpensive way to whiten your teeth, would you be interested?..... Yes No
2. If you could change one thing about your smile, what would it be? _____
3. Why did you leave your last dentist? _____
4. What did you like the most about any dentists you have ever seen? _____
5. Have you been under the care of a medical doctor during the past two years (other than routine checkups and physicals)?..... Yes No
   If yes, for what? _____
6. Primary Physician's name and phone number: _____
7. Have you been hospitalized in the last five years? If yes, list: _____
8. Please list medications, drugs, vitamins/supplements, pills (including any over-the-counter medications) you are currently taking:
   _____
9. Please list any medications, drugs, vitamins/supplements, or pills (including any over-the-counter medications) **you have taken in the last two years that are not listed above** _____
10. Are you aware of having an allergic or adverse reaction to any medication or substance?..... Yes No
    If yes, please list _____
11. Do you have any of the following: (circle) CPAP Bitesplint Retainer Other Appliance: _____
    If you do, how often do you wear it? _____
12. Indicate which of the following you have had, or have at present. Circle 'Yes' or 'No' for each item.

a. Heart (Surgery, Disease, Attack)... Yes No
   If yes, indicate type(s) & date(s):_____
   _____
b. Artificial Heart Valve..... Yes No
c. Heart Pacemaker..... Yes No
d. Bacterial Endocarditis..... Yes No
e. Congenital Heart Disease..... Yes No
   If yes, indicate type:_____
f. Stroke(s)..... Yes No
   If yes, indicate date(s)_____
g. Nervous or Anxious..... Yes No
h. History of bisphosphonates therapy or bone building medications such as Zometa or Aredia ..... Yes No
i. Prednisone or Cortisol Medicine... Yes No
j. Diabetes..... Yes No
   Type I or Type II (please circle type)
k. Immuno Suppression..... Yes No
l. Rheumatism..... Yes No
m. Osteoporosis..... Yes No
n. High Blood Pressure..... Yes No
o. Chest Pain..... Yes No
p. Swollen Ankles..... Yes No
q. Kidney Trouble..... Yes No
r. Ulcers..... Yes No
s. Thyroid Problems..... Yes No
t. Glaucoma..... Yes No
u. Emphysema..... Yes No
v. Chronic Cough..... Yes No
w. Tuberculosis..... Yes No
x. Diet (Special/Restricted).. Yes No
y. Asthma..... Yes No
z. Hay Fever..... Yes No
aa. Allergies or Hives..... Yes No
bb. Latex Sensitivity..... Yes No
cc. Tumors..... Yes No
dd. Chemotherapy..... Yes No
ee. Radiation Therapy..... Yes No
   If yes, location(s) on body?
   _____
ff. Hepatitis..... Yes No
   If yes, A, B, or C? _____
gg. Headaches..... Yes No
hh. H.I.V./A.I.D.S..... Yes No
ii. Cold Sores/fever blisters... Yes No
jj. Blood transfusion..... Yes No
kk. Hemophilia..... Yes No
ll. Sickle Cell Disease..... Yes No
mm. Bruise Easily..... Yes No
nn Liver Disease..... Yes No
oo. Yellow Jaundice..... Yes No
pp. Neurological Disorders.... Yes No
qq. Epilepsy or Seizures..... Yes No
rr. Fainting or Dizzy Spells... Yes No

13. Do you experience any popping or clicking in your jaw joint?..... Yes No
14. Have you had an unexplained significant weight gain or loss in the past year? ..... Yes No
15. Do you have any disease, condition, or problem not listed? ..... Yes No
    If yes, please list _____
16. **Women Only – Are you: Pregnant?** Yes No **Nursing?** Yes No **Take birth control medication or shots?** Yes No
    Name/Type: _____

For Office Use Only	

THIELBAR FAMILY DENTAL

PATIENT REGISTRATION

Date: _____ Reason for today's visit? _____

Name: _____ Preferred name _____
LAST FIRST MI

[ ] Female [ ] Male [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Life Partner

Address: _____ _____ _____ _____
NUMBER/STREET APT # OR UNIT # (if applicable) CITY ST ZIP

Telephone: _____ _____ _____ ____/____/____
HOME WORK OR DAYTIME CELL NUMBER DATE OF BIRTH

Social Security No: ____/____/____ Email: _____

Place of Employment or School/Grade: _____ Whom were you referred by? _____

Have any family members been treated at our office, if yes who? _____

Family Information

PLEASE COMPLETE SECTIONS BELOW

	Spouse or If under 18 - Parent/Legal Guardian	**If Under 18 – Other Parent/Legal Guardian**
Name:	_____ LAST FIRST MI	_____ LAST FIRST MI
Address:	_____ NUMBER/STREET APT # OR UNIT # (if applicable)	_____ NUMBER/STREET APT # OR UNIT # (if applicable)
	_____ CITY ST ZIP	_____ CITY ST ZIP
Telephone:	_____ HOME WORK CELL	_____ HOME WORK CELL

Dental Insurance Information

	PRIMARY	**SECONDARY**
Subscriber Name:		
Birth date:		
S.S. # and I.D. #		
Employer:		
Dental Ins. Co.		
Group/Policy No:		

Emergency Information

In case of emergency, contact: **(PLEASE SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD)**

Name: _____ Relationship: _____
(Example: Relative/Friend/Neighbor, etc.)

Address: _____ Phone: _____ Cell: _____

I hereby authorize payment to the provider, Scott E. Thielbar DDS, PC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of my dental treatment. I hereby authorize the Doctor to administer such medications and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history on the reverse side of this form are correct to the best of my knowledge. I also acknowledge and accept that I will be charged a $25 fee for any no-show appointment or failure to provide 24 hours notice when cancelling or changing an appointment.

Signature of Patient or Parent/Legal Guardian: _____ Date: _____

OVER PLEASE →