Gentle Care For The Entire Family
Bryan M. Dahler D.D.S., P.C.
Family Dentistry

303-421-8753
7575 W. 20Th Ave. Lakewood Co. 80214

We would like to get to know you!

Name_____ **DATE OF BIRTH**_____
ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____
HOME PHONE_____**CELL PHONE**_____**WORK PHONE**_____
EMPLOYER_____**ADDRESS**_____
SOCIAL SECURITY NUMBER_____
MARITAL STATUS_____ **SPOUSE'S NAME**_____
WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE INFORMATION

INSURED'S NAME_____**INSURED'S SSN**_____
INSURED'S EMPLOYER_____
INSURANCE COMPANY_____**GROUP NUMBER**_____
INSURANCE ADDRESS_____

MEDICAL HISTORY FORM

ARE YOU IN GOOD HEALTH? ***YES/NO***
HAS THERE BEEN ANY CHANGE IN YOUR HEALTH IN THE PAST YEAR? ***YES/NO***
MY LAST PHYSICAL EXAM WAS ON _____
ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? ***YES/NO***
IF SO, FOR WHAT CONDITION? _____
PHYSICIAN NAME_____ADDRESS/PHONE_____
HAVE YOU HAD ANY SERIOUS ILLNESS, SIGNIFICANT OPERATION OR HOSPITALIZATION WITHIN THE PAST 5 YEARS? ***YES/NO***
ARE YOU TAKING ANY MEDICATION'S INCLUDING NON-PERSCRIPTION, HOMEOPATHIC OR "NATURAL" REMEDIES INCLUDING DIET PILLS OR VITAMINS? ***YES/NO*** PLEASE LIST: _____
DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

DAMAGE TO HEART VALVES, ARTIFICIAL VALVES, OR HEART MURMUR? ***YES/NO***
RHEUMATIC HEART DISEASE? ***YES/NO***
HEART TROUBLE, HEART ATTACK, ANGINA, HIGH BLOOD PRESSURE, STROKE, ARTERIOSCLEROSIS, OR ANY OTHER HEART CONDITION? ***YES/NO***
OTHER_____
CHEST PAIN UPON EXERTION? ***YES/NO***
SHORTNESS OF BREATH AFTER MILD EXERCISE? ***YES/NO***
DO YOUR ANKLES SWELL? ***YES/NO***
SINUS TROUBLE? ***YES/NO*** **EXPLAIN**_____
ASTHMA OR HAY FEVER? ***YES/NO***
FAINTING SPLELLS OR SEZURES? ***YES/NO*** **EXPLAIN:** _____
DIABETES? ***YES/NO*** **TYPE:** _____
HEPATITIS, JAUNDICE, LIVER DISEASE? ***YES/NO*** **EXPLAIN:** _____

FREQUENT OR RECURRING MOUTH SORES? ***YES/NO***

THYROID PROBLEMS? ***YES/NO*** **EXPLAIN:** _____

RESPIRATORY PROBLEMS,EMPHYSEMA,BRONCHITIS, ETC. ***YES/NO***

ARTHRITIS OR PAINFUL SWOLLEN JOINTS INCLUDING JAW JOINT (TMJ)? ***YES/NO***

STOMACH ULCER OR HYPERACIDITY? ***YES/NO***

KIDNEY TROUBLE? ***YES/NO***

TUBERCULOSIS? ***YES/NO***

PERSISTENT SWOLLEN NECK GLANDS? ***YES/NO***

LOW BLOOD PRESSURE? ***YES/NO***

EPILEPSY OR NEUROLOGICAL DISORDER? ***YES/NO*** **EXPLAIN:**_____

CANCER OR HISTORY OF CANCER? ***YES/NO*** **EXPLAIN**_____

HAVE YOU EVER HAD TREATMENT FOR A TUMOR OR GROWTH? ***YES/NO***

EXPLAIN:_____

ANY DISEASE, DRUG OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM? ***YES/NO*** **EXPLAIN:**

_____

HAVE YOU HAD ABNORMAL BLEEDING? ***YES/NO*** **EXPLAIN:**_____

EVER REQUIRED A BLOOD TRANSFUSION? ***YES/NO*** **EXPLAIN:** _____

DO YOU HAVE A BLOOD DISORDER SUCH AS ANEMIA? ***YES/NO***

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO:

- LOCAL ANESTHETICS? ***YES/NO***
- PENICILLIN OR ANTIBIOTICS? ***YES/NO***
- SULFA DRUGS? ***YES/NO***
- BARBITURATES OR SLEEPING PILLS? ***YES/NO***
- ASPRIN? ***YES/NO***
- IODINE? ***YES/NO***
- CODEINE OR OTHER NARCOTICS? ***YES/NO***
- LATEX OR RUBBER PRODUCTS? ***YES/NO***
- **OTHER**_____

HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? ***YES/NO***

EXPLAIN:_____

DO YOU HAVE ANY OTHER CONDITION OR DISEASE YOU THINK THE DOCTOR SHOULD KNOW ABOUT? **IF SO,**

PLEASE EXPLAIN:_____

CHIEF DENTAL COMPLAINT: _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF THE STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

DATE: _____ **PATIENT'S SIGNATURE:** _____

PLEASE PRINT NAME: _____

FOR COMPLETION BY THE DOCTOR

COMMENTS ON PATIENT INTERVIEW CONCERNING MEDICAL HISTORY:

_____

SIGNIFICANT FINDINGS FROM QUESTIONNAIRE OR ORAL REVIEW:

_____

DENTAL MANAGEMENT CONSIDERATIONS:

_____

DATE: _____ **DOCTOR SIGNARURE:** _____

MEDICAL HISTORY UPDATE:

DATE	**COMMENTS**	**SIGNATURE**
_____	_____	_____
_____	_____	_____