Name_____ Date_____

MEDICAL HISTORY

Have you had any of the following medical Problems?

AIDS/HIV Positive	○Yes ○No	Emphysema	○Yes ○No	Leukemia	○Yes ○No
Anaphylaxis	○Yes ○No	Epilepsy or Seizures	○Yes ○No	Liver Disease	○Yes ○No
Anemia	○Yes ○No	Excessive Bleeding	○Yes ○No	Low Blood Pressure	○Yes ○No
Angina	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No	Lung Diseases	○Yes ○No
Arthritis/Gout	○Yes ○No	Frequent Headaches	○Yes ○No	Mitral Valve Prolapse	○Yes ○No
Artificial Heart Valve	○Yes ○No	Glaucoma	○Yes ○No	Pain in jaw Joints	○Yes ○No
Artificial Joint	○Yes ○No	Heart Attack/Failure	○Yes ○No	Parathyroid Disease	○Yes ○No
Asthma	○Yes ○No	Heart Murmur	○Yes ○No	Psychiatric Care	○Yes ○No
Blood Disease	○Yes ○No	Heart Pace Maker	○Yes ○No	Radiation Treatments	○Yes ○No
Breathing Problem	○Yes ○No	Heart Trouble/Disease	○Yes ○No	Renal Dialysis	○Yes ○No
Bruise Easily	○Yes ○No	Hemophilia	○Yes ○No	Sickle Cell Disease	○Yes ○No
Cancer	○Yes ○No	Hepatitis A	○Yes ○No	Sinus Trouble	○Yes ○No
Chemotherapy	○Yes ○No	Hepatitis B or C	○Yes ○No	Stomach/Intestinal Disease	○Yes ○No
Chest Pains	○Yes ○No	Herpes	○Yes ○No	Stroke	○Yes ○No
Cold Sores/Fever Blisters	○Yes ○No	High blood Pressure	○Yes ○No	Thyroid Disease	○Yes ○No
Congenital Heart Disorder	○Yes ○No	Hives or Rash	○Yes ○No	Tobacco Use	○Yes ○No
Cortisone Medicine	○Yes ○No	Hypoglycemia	○Yes ○No	Tuberculosis	○Yes ○No
Diabetes	○Yes ○No	Irregular Heartbeat	○Yes ○No	Tumors or Growths	○Yes ○No
Drug Addiction	○Yes ○No	Kidney Trouble	○Yes ○No	Ulcers	○Yes ○No

Have you ever had any serious illness not listed above? ○Yes ○No If yes, please explain: _____

Women: Are you
Pregnant/Trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Office Use Only: Doctor's Comments _____

_____

Have you experienced any other physical or mental disorder that is not listed above? ○Yes ○No
If yes, please describe: _____
Are you allergic to any of the following?
Penicillin ○Yes ○No Amoxicillin ○Yes ○No Codeine ○Yes ○No Dental Anesthetic ○Yes ○No
Latex ○Yes ○No Acrylic ○Yes ○No Metal ○Yes ○No
Are you allergic to any other drugs? ○Yes ○No If Yes, please list: _____
Are you presently under the care of a physician for any illness? ○Yes ○No If yes, please explain_____

_____

List any drugs or medications presently being taken: _____
Have you ever been hospitalized? ○Yes ○No If yes, please explain_____

DENTAL HISTORY

YES NO
___ ___ Do you have pain with chewing, yawning, or wide opening?
___ ___ Does your jaw make noise and is pain associated with the sounds?
___ ___ Have you ever had orthodontic treatment?
Date of last dental check-up and x-rays _____

May we request release of your medical records? ○Yes ○No
What (if anything) would you change about your smile?_____ Do you like your smile?_____
Thank you for your help. If there is any information that you feel might be of value to us during your treatment, please add it here:

_____

_____

PATIENT INFORMATION & MEDICAL HISTORY

ARDEN PREMIER DENTISTRY

ardenpremierdentistry.com

Dr. Jessica O. Planer, DDS
2363 Hendersonville Road, Suite C
Arden, NC 28704
828-684-7063

Patient Information

Date_____

Patient's Name _____ Preferred Name _____ Sex_____
First Middle Last

Street Address_____ Date of Birth _____

Physicians Name _____ Dentist _____

Preferred Number _____ Whom may we thank for referring you? _____

Responsible Party Information

□Single □ Separated
□ Married □Divorced

Name: _____ Marital Status:
First Middle Last

Email Address_____ Preferred Phone # _____ Work # _____

Mailing Address_____
Street/ P.O. Box City State Zip

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security Number_____ Birthdate _____ Relationship to patient _____

Employer_____ Occupation_____ No. Years Employed_____
(if self-employed, list name of business)

Spouse/(Other):_____ Relationship to Patient _____
First Middle Last

Spouse/(Other) Email: _____ Preferred Phone # _____ Work #_____

Mailing Address_____
Street/ P.O. Box City State Zip

Social Security Number_____ Birthdate _____

Employer_____ Occupation_____ No. Years Employed_____
(if self-employed, list name of business)

Dental Insurance Information

Policy Holder's Name_____ Policy Holder's Soc. Sec. #_____Birthdate__/__/__

Insurance Co. _____Group No. _____Subscriber No. _____

Insurance Co. Address _____Phone No._____

Policy Holder's Employer _____Do you have other dental insurance? ○Yes ○No

Emergency Information

Name of nearest relative not living with you _____ _Phone No _____

Address_____ Relationship to patient_____
Street City State Zip

Patient Signature _____ Date _____