MEDICAL HISTORY

Have you had any of the following medical Problems?

Condition	Response	Condition	Response	Condition	Response
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

ardenpremierdentistry.com

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

Patient Information

Date________________

Patient's Name ____________________ (First / Middle / Last) Preferred Name ______________ Sex_____

Street Address________________________ Date of Birth ____________________

Physicians Name ________________________ Dentist ________________________

Preferred Number ______________________ Whom may we thank for referring you? ____________________

Responsible Party Information

Name: ______________________________ (First / Middle / Last) Marital Status: ☐Single ☐ Separated ☐ Married ☐Divorced

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____________________ (if self-employed, list name of business) Occupation________________ No. Years Employed______________

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

Spouse/(Other) Email: ____________________ Preferred Phone # ____________ Work #______________

Mailing Address______________________________ (Street/ P.O. Box / City / State / Zip)

Social Security Number____________________ Birthdate ____________________

Employer____________________ (if self-employed, list name of business) Occupation________________ No. Years Employed______________

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 ________________________ (Street / City / State / Zip) Relationship to patient____________________

Patient Signature ________________________________ Date ________________________