

<18 years

"We Love Kids and Cowards"
John R. Loar, DDS & Associates

Date _____

Patient Name _____

Date of Birth _____ Age _____ Sex _____ Home Phone _____ Preferred Name _____
Other Ph. _____

Address _____
Street _____ City _____ State _____ Zip _____

Fathers Name _____

S.S. No. _____ Last _____ First _____ Middle _____ Address or Same _____ Where Employed _____ Bus. Phone _____
Father/ S.S. No. _____ Mother/ S.S. No. _____ Patient

D.L. _____ Birthday ____/____/____ Father / D.L. _____ Birthday ____/____/____ Mother

E-MAIL ADDRESS: _____ Parent Child

Mothers Name _____

Last _____ First _____ Middle _____ Address or Same _____ Where Employed _____ Bus. Phone _____

Please tell us who referred you to our office? _____

Dental Insurance Information (Be sure all Information is Listed) * **Insured's DOB*** ____/____/____

Insurance Co. Name _____ Policyholder _____ Policy or Certificate No. _____
1. _____
2. _____

Medical History B.P. ____/____

1. Are you in good health? yes, no, don't know. _____; Height - _____ Weight - _____ lb.

2. Your Physician's Name _____ Address _____

Are you under a physician's care now? no, yes -condition _____

3. List any Drugs, Herbs(over the counter or Prescription) being taken at this time(mg & times a day) _____

4. Please circle any illness you have ever had or taken; or Systems you have had problems with:

- | | | | | |
|--|---------------|-----------|---------------------|-----------------|
| allergies | tuberculosis | anemia | kidney / or liver | diabetes |
| asthma | heart trouble | epilepsy | rheumatic fever | aids complex |
| hepatitis | herpes | venereal | high blood pressure | glaucoma |
| endocrine | respiratory | urinary | gastrointestinal | blood disorders |
| depression | neurologic | skeletal | dermal (skin) | cancer |
| taken Fosamax or other Bisphosphonates | osteoporosis | arthritis | other | |

5. Have you ever had trouble with prolonged bleeding after surgery? no, yes - _____

6. Have you ever been tested for HIV (AIDS Virus)? no, yes Results: Positive Negative

7. Have you ever had any unusual reaction to anesthetic or drugs like penicillin, codeine, aspirin, iodine, or others? no yes - list _____

8. Have you ever been told by your Physician to take antibiotic pre-medication before dental treatment because of previous illness, joint replacement, mitral valve prolapse, taken Fen-Phen or Redux, or other medical treatment to prevent systemic bacteremia or SBE. no, yes - specific condition _____

9. Have you been Hospitalized in the last 15 years? ____; any blood transfusions no yes; or is there any other information that should be known about your health? _____

For Females Only- if reached maturity:

1. Are you pregnant? no, yes - trimester 1 2 3
2. Are you nursing? no, yes _____
3. Are you taking birth control pills? no, yes Name _____

MEDICAL UPDATE - REVIEW

| | | |
|------------|--|-----------------------------------|
| Date _____ | Signature of Patient, Parent or Responsible Party - comments _____ | Initials, Asst/11yg/ofMg/Dr _____ |
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

1. What concerns you the most, or reason for the dental visit? _____

2. Do you have pain in your teeth because of heat, cold, or sweets? no, yes - If so, where _____

3. Do you have pain in any part of the mouth or in any tooth while biting or chewing? no, yes - where _____

4. Does food catch between your teeth? no, yes - where _____
5. Do your gums bleed, either in chewing or brushing or at any other time? no, yes - when and where _____

6. Do you clench your teeth during the day? _____
 Have you been made aware of clenching your teeth during the night? _____
7. Do you use a stiff , or soft bristled brush. How often do you brush a day? _____
 Do you avoid any part of your mouth while brushing? _____
8. Do your gums feel irritated, tender or swollen? _____
9. Are you completely **happy with the appearance** of your teeth? yes, no - why not? _____
10. Do you have all your teeth (other than wisdom teeth)? yes, no. _____
11. If not, did you have missing teeth replaced? yes, no. _____
12. Were you told why missing teeth should be replaced? yes, no, n/a
13. Do you lose fillings or break silver fillings? yes, no, n/a
14. Please circle, give dates, and record results if you have ever had; or Circle if you need:
 Orthodontic treatment (braces) _____ Your teeth ground or bite adjusted _____
 Oral Surgery _____ Worn a bite plate or other appliance _____
 Gum treatments or gum surgery _____ Bleaching _____
15. Do you feel Dentures are inevitable? If older -late teens yes, no. _____
16. How often do you have calculus (tartar) removed? (Professional teeth cleaning) Every _____ months.
17. Do you want to keep your teeth as long as possible? yes, no. _____

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services. I authorize the use of slide pictures and/or diagnostic models to be used for professional presentations. I also authorize Dr. Loar/Associates to use anesthetics and medications deemed necessary during my dental treatment and I have been encouraged to ask questions if they should arise about any medication or procedure before or during any Dental treatment. The policy of our office is the parent who requests treatment for the child is responsible for all fees for services rendered. I have received or downloaded a copy of this office's Notice of Privacy Practices (HIPAA).

 Date (today)

X

 Signature of Patient, Parent or Responsible Party

 Asst/Hyg/OHMG/Dr