Kumfer Family Dental LLC

Kumfer Family Dental Medical History

Patient Name: _____ Date of Birth: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If Yes_____
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If Yes_____
Have you ever had a serious head or neck injury?	○ Yes ○ No	If Yes_____
Are you taking any medication, pills, or drugs?	○ Yes ○ No	If Yes_____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If Yes_____
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates	○ Yes ○ No	If Yes_____
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing ☐ Taking Oral Contraceptives

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances? ○ Yes ○ No If Yes_____

Other? ☐ If Yes_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No
Alzhelmer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Breeding	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No
Chest Pain	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No
Cold Sores/Fever Blister	○ Yes ○ No	Heart Murmer	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No		

Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
High Choleterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Irregualar Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No	Tumor or Growths	○ Yes ○ No
Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No

Have you ever had any serious illness not listed? ○ Yes ○ No

If Yes_____

Dental History

When was your last dental visit?

☐ 0 – 6 Months ☐ 6 – 12 Months ☐ 1 – 2 Years ☐ 3+ Years

How often do you brush your teeth?

☐ Two or More Times a Day ☐ Once a Day ☐ 3 – 5 Times a Week ☐ Rarely

How often do you floss?

☐ Daily ☐ 3-4 Times a Week ☐ Rarely ☐ What's Floss?

What type of toothpaste do you use?

☐ Sensitivity Toothpaste ☐ Whitening Toothpaste ☐ Tartar Control Tooth Paste ☐ I am not sure

Do you use an electric toothbrush? ○ Yes ○ No If Yes_____

Have you ever been diagnosed with Periodontal Disease? ○ Yes ○ No If Yes_____

Are you aware of any dental habits? (i.e. Grinding, Sleep Apnea, Wear, etc? ○ Yes ○ No If Yes_____

Do you wear any dental appliances? ○ Yes ○ No If Yes_____

Comments:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X _____ Date: _____

Signature of Patient, Parent, or Guardian

Authorization of Assignment of Benefits

I hereby authorize the release of any information acquired during the course of my examination or treatment by Kumfer Family Dental, and also authorize the payment of insurance benefits directly to the same. I agree that I am responsible for the total charges contained herein. My authorizing signature is on file with this provider.

X _____ Date: _____

Signature of Patient, Parent, or Guardian