FOR OFFICE USE ONLY
- ❑ In computer
- ❑ NP letter
- ❑ Thank you referral letter
- ❑ Scanned

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**ANGELA B. BATESON, DDS**
GENERAL DENTISTRY
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419-425-0303

## PATIENT INFORMATION

**Patient Name** ______________________________ **Date** __________
LAST, FIRST MI (PREFERRED NAME)

**Birth date** __________ **Gender:** ❑Male ❑Female **Family Status:** ❑Married ❑Single ❑Divorced ❑Widow

**Social Security #**__________ **E-mail address** __________

**Address** ______________________________
STREET APARTMENT #
______________________________

**Home Phone** __________ **Work/Ext.** __________ **Cell** __________

**May we leave a treatment message?** ❑Yes ❑No **What type of message may we leave?** ❑Voice message ❑Text message

**Where may we leave treatment messages?** ❑Home phone ❑Cell phone ❑Work phone

**Preferred method to notify you of your appointments** ❑ Home ❑ Work ❑ Cell ❑ E-Mail ❑ Text Message

**Preferred appointment times** ❑ Morning ❑ Afternoon ❑ Evening ❑ Any Time **Preferred appt. days** ❑M ❑ T ❑W ❑Th ❑F

**Employer Name** __________ **Occupation** __________

**Address** ______________________________
STREET CITY STATE ZIP

**Emergency contact:**______________________________
NAME / RELATIONSHIP PHONE

## MEDICAL HISTORY

***(Check DK if you don't know the answer to the question)***

| | YES | NO | DK |
|---|---|---|---|
| **DO YOU WEAR CONTACT LENSES?** | ❑ | ❑ | ❑ |
| **JOINT REPLACEMENT**. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? (please circle) If yes, have you had any complications? __________ | ❑ | ❑ | ❑ |
| Are you scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? | ❑ | ❑ | ❑ |
| Since 2001, were you treated, or presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | ❑ | ❑ | ❑ |

| | YES | NO | DK |
|---|---|---|---|
| Do you use controlled substances (drugs)? | ❑ | ❑ | ❑ |
| Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? (circle one) VERY / SOMEWHAT / NOT INTERESTED | ❑ | ❑ | ❑ |
| Do you drink alcoholic beverages? | ❑ | ❑ | ❑ |
| If yes how much alcohol did you drink in the last 24 hours?__________ | | | |
| If yes, how much do you typically drink in a week?__________ | | | |
| **WOMEN ONLY. Are you:** | | | |
| Pregnant? If yes, number of weeks__________ | | | |
| Taking birth control pills or hormonal replacement? | ❑ | ❑ | ❑ |
| Are you nursing? | | | |

**ALLERGIES.** Please check and list reactions for any allergies you may have:

| | YES | NO | DK |
|---|---|---|---|
| Local anesthetics | ❑ | ❑ | ❑ |
| Aspirin | ❑ | ❑ | ❑ |
| Penicillin or other antibiotics | ❑ | ❑ | ❑ |
| Barbiturates, sedatives, or sleeping pills | ❑ | ❑ | ❑ |
| Sulfa drugs | ❑ | ❑ | ❑ |
| Codeine or other narcotics | ❑ | ❑ | ❑ |
| Other:__________ | ❑ | ❑ | ❑ |

| | YES | NO | DK |
|---|---|---|---|
| Metals | ❑ | ❑ | ❑ |
| Latex (rubber) | ❑ | ❑ | ❑ |
| Iodine | ❑ | ❑ | ❑ |
| Hay fever/seasonal | ❑ | ❑ | ❑ |
| Animals | ❑ | ❑ | ❑ |
| Food | ❑ | ❑ | ❑ |
| Other__________ | ❑ | ❑ | ❑ |

**Have you ever had any of the following?**
**Please check those that apply:**

| | YES | NO | DK |
|---|---|---|---|
| Artificial (prosthetic) heart valve | ❑ | ❑ | ❑ |
| Previous infective endocarditis | ❑ | ❑ | ❑ |
| Damaged valves in transplanted heart | ❑ | ❑ | ❑ |

| | YES | NO | DK |
|---|---|---|---|
| Congenital heart disease (CHD) | ❑ | ❑ | ❑ |
| Unrepaired, cyanotic CHD | ❑ | ❑ | ❑ |
| Repaired (completely) in last 6 months | ❑ | ❑ | ❑ |
| Repaired CHD with residual defects | ❑ | ❑ | ❑ |

***Except for the conditions listed above antibiotic prophylaxis is no longer recommended for any other form of CHD.***

**PLEASE CONTINUE ON BACK OF THIS PAGE**

**Please check any of the following that may apply to you:**

| | YES | NO | DK |
|---|---|---|---|
| Abnormal bleeding | ❑ | ❑ | ❑ |
| AIDS or HIV infection | ❑ | ❑ | ❑ |
| Anemia | ❑ | ❑ | ❑ |
| Arthritis | ❑ | ❑ | ❑ |
| Asthma | ❑ | ❑ | ❑ |
| Autoimmune | ❑ | ❑ | ❑ |
| Blood transfusion. If yes, date:________ | ❑ | ❑ | ❑ |
| Cancer/chemotherapy/Radiation Treatment | ❑ | ❑ | ❑ |
| Cardiovascular disease. If yes, specify below: | ❑ | ❑ | ❑ |

____Angina
____Arteriosclerosis
____Artificial heart valves
____Congenital heart defects
____Congestive heart failure
____Coronary artery disease
____Damaged heart valves
____Heart attack
____ Heart murmur
____ High blood pressure
____ Low blood pressure
____ Mitral valve prolapsed
____ Pacemaker
____ Rheumatic heart disease/Rheumatic fever

| | YES | NO | DK |
|---|---|---|---|
| Chest pain upon exertion | ❑ | ❑ | ❑ |
| Chronic pain | ❑ | ❑ | ❑ |
| Diabetes Type I (insulin dependent), or Type II | ❑ | ❑ | ❑ |
| Eating disorder. If yes, specify:________ | ❑ | ❑ | ❑ |
| Epilepsy | ❑ | ❑ | ❑ |
| Excessive bleeding | ❑ | ❑ | ❑ |
| Fainting spells or seizures | ❑ | ❑ | ❑ |
| GE Reflux /persistent heartburn | ❑ | ❑ | ❑ |
| Glaucoma | ❑ | ❑ | ❑ |
| Growths/tumors | ❑ | ❑ | ❑ |
| Hemophilia | ❑ | ❑ | ❑ |
| Hepatitis, jaundice or liver disease | ❑ | ❑ | ❑ |
| Recurrent infections. If yes, indicate type ________ | ❑ | ❑ | ❑ |
| Kidney disease | ❑ | ❑ | ❑ |
| Mental health disorders. If yes, specify ________ | ❑ | ❑ | ❑ |
| Malnutrition | ❑ | ❑ | ❑ |
| Neurological disorders. If yes, specify ________ | ❑ | ❑ | ❑ |
| Osteoporosis | ❑ | ❑ | ❑ |
| Persistent swollen glands in neck | ❑ | ❑ | ❑ |
| Recurrent infection. If yes, specify ________ | ❑ | ❑ | ❑ |
| Respiratory problems, If yes, specify below: | ❑ | ❑ | ❑ |
| ___Emphysema ___Bronchitis, etc. | ❑ | ❑ | ❑ |
| Rheumatoid arthritis | ❑ | ❑ | ❑ |
| Severe headaches/migraines | ❑ | ❑ | ❑ |
| Severe or rapid weight loss | ❑ | ❑ | ❑ |
| Sexually transmitted disease | ❑ | ❑ | ❑ |
| Sinus trouble | ❑ | ❑ | ❑ |
| Sleep disorder | ❑ | ❑ | ❑ |
| Sores or ulcers in the mouth | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ |
| Systemic lupus erythematosus | ❑ | ❑ | ❑ |
| Tuberculosis | ❑ | ❑ | ❑ |
| Thyroid problems | ❑ | ❑ | ❑ |
| Ulcers | ❑ | ❑ | ❑ |
| Do you have any disease not listed that I should know about? | ❑ | ❑ | ❑ |

Please explain ________

Please list all prescribed and over-the-counter medications you take:________

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑Yes ❑No
If yes, please list ________

Name of physician or dentist who made the recommendation ________ Phone number ________

Name of primary care physician ________ Phone number ________

## DENTAL HISTORY

| | YES | NO |
|---|---|---|
| Are you having dental discomfort today? | ❑ | ❑ |
| Are you missing any teeth other than wisdom teeth or orthodontic extractions? | ❑ | ❑ |
| Have missing teeth been replaced? | ❑ | ❑ |
| Do your gums bleed when you brush or floss? | ❑ | ❑ |
| Are you concerned about gum disease? | ❑ | ❑ |
| Do you have any concerns about the appearance of your teeth? | ❑ | ❑ |
| Does it hurt to bite or chew? | ❑ | ❑ |
| Do you clench or grind your teeth? | ❑ | ❑ |
| How would you describe your dental health? ❑Excellent ❑Good ❑Fair ❑Poor | | |
| Have you ever had a problem with: | | |
| Local anesthetic? | ❑ | ❑ |
| Previous dental treatment? | ❑ | ❑ |
| Nitrous oxide sedation? | ❑ | ❑ |
| Cleaning or periodontal therapy? | ❑ | ❑ |
| Do you want to become a regular continuing care patient in our practice? | ❑ | ❑ |

Do you take antibiotics for dental appointments? ❑Yes ❑No If yes, what antibiotic do you take? ________

When was your last cleaning or periodontal therapy? ________

What factors are most important for your satisfaction with our office? ________

Do you have any additional concerns or comments?________

## CONSENT FOR TREATMENT

**NOTE: BOTH Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.** I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form

Signature of Patient / Legal Guardian ________ Date ________