2013

Personal Health & Dental History

Please fill out this form honestly and completely to the best of your ability

Daedalus Denture Concepts, Inc.
1/1/2013

All information provided will be kept confidential in accordance with HIPPA (Health Insurance Portability and Accountability Act). We have copies available of this document for your convenience.

First Name:_____ Last Name:_____ *Middle Initial:*_____.

Nickname*:*_____ Birth date*:*_____/_____/_____ *Age:*_____ *Sex:* M / F

*Address:*_____.

*City:*_____ *State:*_____ *Zip:*_____.

Primary Phone:(____)_____ Secondary Phone:(____)_____.

May we leave a detailed message on your phone: Y / N .

Emergency contact information: Name_____ Relationship_____.

Cell Phone:_____ Home phone:_____.

Person responsible for paying bills and relationship:_____.

Do you have Dental Insurance: Y / N . Insurance Company:_____.

Employer (If insurance is thru employer):_____.

If Insurance is through another person, we will need this person's:

Dental Insurance:_____ . Employer:_____.

Insurance ID#:_____. Relationship:_____.

First Name:_____ Last Name:_____ *Middle Initial:*_____.

Birthdate: _____/_____/_____ Address:_____.

How did you hear about our office:_____.

Medical Alerts

Allergic to:

- ☐ No Known Allergies
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Epinephrine
- ☐ Iodine
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other Narcotics

Other Substances:_____.

Check if Applicable:

- ☐ AIDS/HIV Infection
- ☐ Alcohol Use
- ☐ Anemia/Leukemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma/Hay Fever
- ☐ Back Problems
- ☐ Cancer/Tumor or Growth
- ☐ Chemotherapy
- ☐ Radiation
- ☐ COPD
- ☐ Color Blindness
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent dry Mouth
- ☐ Heart Problems
- ☐ Pace Maker
- ☐ Hemophiliac
- ☐ Hepatitis/Jaundice
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives/Skin Rash
- ☐ Jaw Pain
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Slow to Clot Blood
- ☐ Unusual Weight Loss

Other:_____.

Medical Questionnaire

Family Physician:_____. Clinic:_____.

Phone:_____.

Are you currently under the care of a Physician: Y / N .

If yes, please list current health conditions:_____.

_____.

Are you currently taking any medications: Y / N . If yes, please list:_____.

._____.

._____.

Dental Questionnaire

Name of current dentist:_____. May we contact your current dentist: Y / N .

Last dental exam date:____/____/_____. Do you see your dentist regularly: Y / N .

Do you have more dental work to be completed Y / N .

What do you currently wear: _____. Upper Denture _____. Lower Denture
_____. Upper Partial _____ Lower Partial

How long have you had your current Partial or Denture: Upper Plate: Years _____.
Lower Plate: Years _____.

Date of last reline:____/____/_____.

Do you use adhesive with you current denture or partial: Y / N .

Do you sleep with you denture or partial in place: Y / N .

Do you Have any Head, Neck or Jaw injuries: Y / N .

Do you have any popping or clicking of the jaw: Y / N .

Do you Clinch or Grind your teeth: Y /N .

Do you have a sensitivity to gagging: Y /N .

Are you happy with your Smile: Y / N .

Please indicate if any of the following apply:

- ☐ Loose denture or partial
- ☐ Poorly fitting denture or partial
- ☐ Sore or hotspots
- ☐ Cheek biting
- ☐ Uneven bite
- ☐ Broken or cracked denture/partial
- ☐ Broken clasp
- ☐ Missing teeth
- ☐ Worn teeth
- ☐ Staining

Please briefly describe any additional problems you are currently experiencing:

_____.

I confirm that the information I have provided on this form is complete and accurate. If my medical status or any of my medications change, I will let the staff at Daedalus Denture Concepts know.

I also understand I have rights of privacy regarding my health information and that Daedalus Denture Concepts will only share my information with my other health care providers as required and with other third-party payers for the services they are providing me.

Signature:_____ Date ____/____/_____.