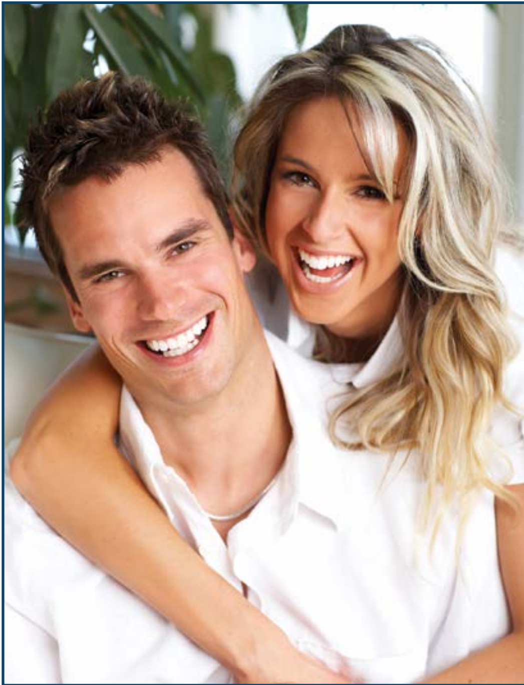
Adult Pre-Clinical History



Today's Date: ______________

ABOUT YOU

Name: ____ ❑ Female ❑ Male

Nickname: ________________________ Social Security #: __________________

Address: ____

City: ____________________________________ State: ________ Zip: _________

Home Phone: ______________________ Business Phone: ___________________

Cell Phone: ____

Birthdate: _____/______/______ Marital Status: ❑ Single ❑ Married

E-mail Address: ____

Name of Spouse: ____

Names of Children: ____

How do you enjoy spending your free time? ____________________________

Who can we thank for referring you to our office? _______________________

How did you hear about us? ____

EMERGENCY INFORMATION

Person to Contact: ____

Relationship: ____________________________ Phone: ____________________

❑ I give permission for Delano Dental to share my medical and account information with:

____

I, _________________________________, agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Delano Dental.
Initials: _______

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however, failing to attend your appointment or canceling without adequate notice more than once will result in a $50 charge. Initials: ___

707 Elm Avenue East • Delano, MN 55328 • Phone (763) 972-2800 • Fax (763) 972-9064
www.DelanoDental.com

MEDICAL HISTORY

Name of Personal Physician: ____________________

Address: ____________________ Phone Number: ____________________

Approximate date of last visit: ____________ Current health condition: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you had any serious health problems in the last five years? ❑ Yes ❑ No If yes, please explain: ____________

____

(For women) Are you currently pregnant? ❑ Yes ❑ No If yes, how many months? ____________

Please list prescription medications: ____________________

____

Please list vitamin/herbal supplements: ____________________

____

Do you know your blood pressure? ❑ Yes ❑ No If yes, what is it? ____________________

Please check if you're allergic to any of the following:

❑ Local Anesthetics
❑ Penicillin/Other Antibiotics
❑ Barbiturates/Sedatives/Sleeping Pills
❑ Sulfa Drugs
❑ Aspirin
❑ Shellfish/Iodine/Red Wine
❑ Codeine/Other Narcotics
❑ Latex Sensitivity
❑ Other ____________________

Do you take a pre-med? ❑ Yes ❑ No If yes, which one? ____________________

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

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Anaphylaxis
❑ Anemia
❑ Arthritis/Gout
❑ Artificial Heart Valve
❑ Artificial Joint
❑ Asthma
❑ Back Problems
❑ Birth Control
❑ Blood Disease
❑ Blood Thinners
❑ Blood Transfusion
❑ Breathing Problem
❑ Bruise Easily
❑ Cancer
❑ Chemical Dependency
❑ Chemotherapy
❑ Chest Pains
❑ Circulatory Problems
❑ Cold Sores/Fever Blisters
❑ Congenital Heart Disorder
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Easily Winded
❑ Emphysema
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Fainting Spells/Dizziness
❑ Fosamax
❑ Frequent Cough
❑ Frequent Diarrhea
❑ Genital Herpes
❑ Glaucoma
❑ Hay Fever
❑ Head Injury
❑ Heart Attack/Failure
❑ Heart Murmur
❑ Heart Pacemaker
❑ Heart Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ High Cholesterol
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Jaw Pain
❑ Kidney Problems
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Mental Disorders
❑ Mitral Valve Prolapse
❑ Nervous Disorders
❑ Osteoporosis
❑ Pain in Jaw Joints
❑ Parathyroid Disease
❑ Psychiatric Care
❑ Radiation Treatments
❑ Recent Weight Loss
❑ Renal Dialysis
❑ Rheumatic Fever
❑ Rheumatism
❑ Scarlet Fever
❑ Shingles
❑ Sickle Cell Disease
❑ Sinus Trouble
❑ Spina Bifida
❑ Stomach/Intestinal Disease
❑ Stroke
❑ Swelling of Limbs
❑ Thyroid Disease
❑ Tobacco Habit
❑ Tonsillitis
❑ Tuberculosis
❑ Tumors or Growths
❑ Ulcers
❑ Viagra
❑ Venereal Disease
❑ Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain: ____________________

____

When a health care worker is exposed to my blood or body fluids through a needle stick, cut, or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). Initial: ________

The information I have given is true and accurate to the best of my knowledge.

Signature: ____________________ Date: ____________________