McPherson Dental Care

700 N. Maple Street • McPherson, KS 67460 (620)241-5000

Patient Name: ____________________ ____________________ ___ ____________________
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental health so we may serve you more effectively and efficiently for your overall health and well-being.

What is the reason for your dental visit today?

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When was your last visit to the dentist? What is your prior dentist's name, address and phone number?

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Why did you leave your last dentist?

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Have you had an upsetting dental experience?

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Please check any of the following that apply:

- ☐ Are any of your teeth causing you pain?
- ☐ Do your teeth have sensitivity to hot, cold, or pressure?
- ☐ Do you use tobacco?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Are you aware of clenching or grinding your teeth (either when awake or asleep)?

If yes, please explain

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If you could do anything to change your teeth or smile, what would it be?

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Medical History

Your primary care physician's name, address and phone number:

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Your pharmacy's name, phone number, city and state :

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Have you been told that you need a pre-medication or antibiotic prior to dental treatment? ◯ Yes ◯ No

If yes, what has been prescribed?

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Have you been hospitalized within the past 5 years due to surgery or illness? ◯ Yes ◯ No

Within the past year, have their been any changes in your general health? ◯ Yes ◯ No

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

Due date: ____________

Other Information:

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Please list any medications or supplements you are currently taking:

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Please mark all that apply:

- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Artificial heart valve
- ☐ Rheumatic fever
- ☐ Joint replacement
- ☐ Autoimmune disease
- ☐ Blood thinner medication
- ☐ Pacemaker
- ☐ Heart attack in last 6 months
- ☐ High blood pressure
- ☐ Stroke in last 6 months
- ☐ Diabetes
- ☐ Respiratory problems
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Kidney disease
- ☐ HIV
- ☐ Epilepsy/seizures
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Acid reflux
- ☐ No known allergy
- ☐ Allergy to peniclin
- ☐ Allergy to sulfa
- ☐ Allergy to clindamycin
- ☐ Allergy to tetracycline
- ☐ Allergy to codiene
- ☐ Allergy to ibuprofen (Advil)
- ☐ Allergy to acetaminophen (Tylenol)
- ☐ Allergy to latex
- ☐ Allergy to other

Please explain response. Do you have other conditions or illnesses we should be made aware of? If yes, please explain.

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Additional Information:

Emergency Contact: Name Phone

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of:

○ patient ○ parent ○ guardian

Response Date: __________