Portage Dental

Welcome to Portage Dental

Patient Name:_____ SS#:_____--_____--_____
Address:_____ Date of Birth:____/____/_____ Sex: M or F
City:_____ State:_____ Zip:_____ Cell Phone #:_____
Patient or Parent's Employer:_____
City:_____ State:_____ Zip:_____ Work Phone #:_____
How did you hear about us?:_____
Person to Contact in Case of Emergency:_____Phone #:_____
Relationship of Emergency Contact to Patient:_____
Name of Person Responsible for this Account:_____Phone #:_____
Relationship to Patient:_____
Address:_____Date of Birth:___/___/____ Sex: M or F
Responsible Person's Employer:_____
City:_____State:_____ Zip:_____ Work Phone #:_____
Dental Insurance:_____ Co-Insurance_____ Group#:_____
Name of Relative Not at Your Address:_____
Relationship_____ Phone #:_____

Email: _____

DENTAL HISTORY

We Would Like To Know You Better

Date:___/___/____ Name:_____
What is your primary concern?:_____
_____

Are your teeth sensitive to: (Please circle) Heat Cold Sweets Biting Pressure
Do your gums bleed when you brush? Yes or No
Have you noticed any gum swelling around any teeth? Yes or No
Do you have an unpleasant taste or odor in your mouth? Yes or No
Any Problems of the Jaw: Clicking of the jaw Yes or No
Pain (joints. ear, side of face) Yes or No
Difficulty opening or closing Yes or No
Difficulty chewing Yes or No
What would you like to change about the appearance of your teeth or smile?_____
_____
_____
Have you had a reaction to local anesthetic? Yes or No
If yes please describe the reaction:_____
Do you smoke: Yes or No
Do you feel you will eventually wear artificial dentures? Yes or No
Do you have any dental fears? Yes or No
Why did you leave your last dentist? _____
_____
What is your present dental concern? _____
_____

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that I am responsible for all charges whether or not paid by insurance.

_____ ____/____/_____
Signature Date

Time 10:39 AM | PORTAGE DENTAL | Date 6/19/2014

Eaglesoft Medical History A(Copy)

Patient Name: | Birth Date: | Date Created:

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

List your general physician and the office phone number

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 medications, 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 medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
HAVE YOU HAD MALARIA OR ARE YOU CURRENTLY BEING TREATED FOR MALARIA?	Yes No	If yes	
WHAT IS YOUR ETHNICITY?		omment	
WHAT IS YOUR RACE?			
wHAT IS YOUR PREFERRED LANGUAGE?			

Martial Status _____

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	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed	Yes No	If yes	
Weight			
Height			
Blood Pressure			

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.

Signature of Patient, Parent or Guardian:

X_____ Date:_____