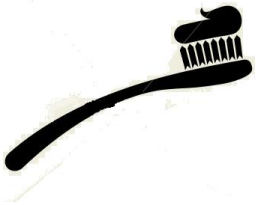

Welcome

Thomas M. Kiefer, D.M.D

Medical History

Welcome to our practice. We will use our very best care, skills and judgment in rendering your dental treatment. Please complete this confidential medical/dental history.

Last Name_____ Dr Mr Mrs Ms First Name_____ Middle Initial ___ Preferred Name_____

Address _____ City _____ State _____ Zip _____

Home Phone ( )_____Work Phone ( )_____ Cell Phone ( )_____

E-Mail: _____

SS# _____ DOB _____ Marital Status _____ Sex □ Male □ Female

Whom may we thank for referring you?_____

Primary Dental Insurance
Employer _____
Who is responsible for this account? _____ Relationship to Patient_____
Insurance Co. _____ Group # _____

Physician _____ Phone ( )_____ Date of last exam _____

Are you now or have you been recently under treatment by a physician? □ Yes □ No
Reason_____

Have you ever been hospitalized or had a serious illness? □ Yes □ No
Reason_____

Are you taking any medication(s) including non-prescription medications? □ Yes□ No
If yes, please
list_____

Do you use tobacco? □ Yes □ No

Check any of the following that you are taking or have taken: □ Cortisone drugs □ Steroids □ Sedatives
□ Anticoagulants □ Aspirin □ Blood thinners_____ □ MAO Inhibitors □ Tranquilizers
□ Anti depressants □ Medication before dental treatment

Do you have allergies/adverse reactions to any of the following: □ Sulfa Drugs □ Local Anesthetics (i.e. Novocaine)
□ Penicillin or other antibiotics □ Barbiturates (i.e. Codeine) □ Sedatives □ Iodine □ Aspirin □ Latex Rubber
□ Any Metals (i.e. nickel, mercury, etc.) □ Other_____

Continued from previous page.

WOMEN ONLY: Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptive (pills, shots or implant)? ☐ Yes ☐ No
Are you taking estrogen therapy? ☐ Yes ☐ No

MEDICAL HISTORY Patient Name_____

Do you have or have you had any of the following:

☐ Abnormal Bleeding
☐ Alcohol Abuse
☐ Allergies
☐ Anemia
☐ Angina Pectoris
☐ Arthritis
☐ Artificial Bones
☐ Artificial Heart
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Transfusion
☐ Cancer
☐ Chemotherapy
☐ Colitis
☐ Congenital Heart
☐ Diabetes
☐ Difficulty Breathing
☐ Drug Abuse
☐ Emphysema
☐ Epilepsy
☐ Fainting Spells
☐ Fever Blisters
☐ Frequent Headaches
☐ Glaucoma
☐ HIV+/AIDS
☐ Heart Attack
☐ Heart Stint
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ Kidney Problems
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pace Maker
☐ Psychiatric Problems
☐ Radiation Therapy
☐ Rheumatic Fever
☐ Seizures
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice
☐ Other_____
☐ Other_____
☐ Other _____

Do YOU consider yourself a nervous dental patient? ☐ Yes ☐ No
Have you used Nitrous Oxide (laughing gas) or sedation during dental visits? ☐ Yes ☐ No
Have you had modern homecare techniques demonstrated recently? ☐ Yes ☐ No

What is the main reason for your visit today? _____
_____
_____

My signature on this form indicates that I have read and understand the above information and that the above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health.

Signature_____ Date_____

Document Address: MainData\officefiles\frontdesk\healthhistory updated 03/09/2015