# ROBERT L. MACHEN, D.D.S., M.S.

**PERIODONTICS ♦ DENTAL IMPLANTS**

Answers to the following questions are for our records only and will be considered and kept confidential.

PATIENT'S NAME________________________________ SS#_____________________Date__________ ___________

Date of Birth____________Age_______Height________Weight________Marital Status__________ Gender: M F

Home Address_________________________________City_________________St.____________Zip_______________

HomeTel.___________________Cell__________________Business Tel.________________email__________________

Occupation______________________________Employer__________________________________________________

Business Address_________________________________City_________________St.____________Zip____ _______

Spouse's Name______________________________SS#__________________Spouse's D.O.B____________________

Spouse's Occupation__________________________Employer____________________Bus. Tel.___________________

PERSON TO CONTACT IN AN EMERGENCY______________________Relation____________Tel.________________

PARTY RESPONSIBLE FOR PAYMENT____________________Bus. Tel.____________Res. Tel.________________

METHOD OF PAYMENT: Visa________ MC________ Discover________ Check________ Cash_________

Who may we thank for referring you?_____________________Reason for this visit?_____________________________

IF YOU HAVE INSURANCE PLEASE COMPLETE THE FOLLOWING:

Dental Insurance Co.______________________________________Tel.__________________________________ ______

Name of Insured_________________________________SS# of Insured_________________D.O.B.________________

Group No._______________________________________ ID#______________________________________________

## *HEALTH HISTORY*

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out areas, which pertain to you.

DENTAL HISTORY: Your Dentist______________________City___________________ How long__________________

Last Dental Visit_________________Date of last cleaning________________Last full mouth xrays__________________

Check any of the following you have had or currently have:

___Mouth Discomfort
___Gum Abscesses
___Swollen or Tender Gums
___Loose or shifting teeth
___Bruise Easily
___Clicking, Popping or Pain in Jaw Joints
___Grinding or Clenching Your Teeth
___Sensitive Teeth (hot, cold or sweets)
___Awaken with Sore Jaw
___Trouble Chewing or Speaking
___Orthodontic Treatment
___Had Immediate Relatives Lose all of Their Natural Teeth
___Bad Dental Experience
___Mouth Odor or Bad Taste
___Cold Sores or Fever Blisters
___Other Oral Lesions
___Previous Periodontal Treatment
___Scaling/Root Planing
___Gum Surgery
___Complications with or Following Dental or Surgical Treatment.
___Complications Recovering from Anesthesia
___Fear of Dental Treatment

How often do you brush?___________________________How often do you floss?____________________________

Do you use any other oral hygiene products?____________________________________________________________

Do you want to keep your teeth? ___Yes, no matter what it takes ___Don't know
___Yes, if it's not too much trouble ___Don't care

Please continue on reverse side

# MEDICAL HISTORY

1. Name of Physician_______________________________________ Phone No.______________________________

   Date of last physical exam_________________________________ Findings__________________________________
2. How would you describe your health? Excellent Good Fair Poor
3. Are you aware of any changes in your general health in the last year? NO YES_______________________
4. Have you been hospitalized for illness or surgery in the past five years? NO YES_______________________
5. Have you been under a medical doctor's care during the past two years? NO YES_______________________
6. Have you ever had excessive bleeding that required special treatment? NO YES_______________________
7. Is there any history of diabetes in your family? NO YES_______________________
8. DO YOU SMOKE? NO YES How much?__________________ How long?_______________________
9. Do you drink alcohol? NO YES How much?__________________ How long?_______________________
10. Do you use recreational (illegal) drugs? NO YES
11. List all medications you are now taking (include all over-the-counter drugs, vitamins and herbs).

***Please inform us if you are taking methadone, morphine or any medication for previous addiction or chronic pain.***

___________________________________________________________________________________________________

___________________________________________________________________________________________________

12. Are you taking any blood thinners, including aspirin, on a daily basis? NO YES_________________________

**PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO**:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Penicillin | Doxycycline | Novocaine | Codeine | Valium | Aspirin | Vicodin | Latex |
| Erythromycin | Sulfa Drugs | Carbocaine | Demerol | Versed | Tylenol | Lortab | Aleve |
| Tetracycline | Keflex | Xylocaine | Nubain | Halcion | Ibuprofen | Darvocet | |

Others______________________________________________________________________________________________

**PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU NOW HAVE OR HAVE EVER HAD**:

| | | | |
|---|---|---|---|
| Heart Trouble | Ankles Swell | Diabetes | Psychiatric Care |
| Heart Attack or Disease | Anemia | Frequent Thirst/Urination | Ulcers |
| Angina or Chest Pain | Sickle Cell Disease | Stroke | Contact Lenses |
| High Blood Pressure | Artificial Joints | Epilepsy/Seizures | Hepatitis A B or C |
| Low Blood Pressure | Frequent Headaches | Liver Disease/Jaundice | Pacemaker |
| Fainting or Dizzy Spells | AIDS/HIV | Rheumatic Fever | Thyroid Problems |
| Heart Surgery | Cancer or Tumors | Blood Transfusion | Congenital Heart Lesions |
| Heart Murmur | Radiation Treatment | Hemophilia | Artificial Heart Valve |
| Asthma | Chemotherapy | Allergies | Mitral Valve Prolapse |
| Sinus Problems | Arthritis/Rheumatism | Kidney/Bladder Disease | Dry Mouth |
| Prostate Problems | Venereal Disease | Sleep apnea | Emphysema/TB |
| Shortness of Breath (upon mild exertion) | Unintentional Weight Gain/Loss | | |

Surgery? Please describe_______________________________________________________________________________

If female, are you ____Pregnant or trying to get pregnant? ___Nursing? ___Taking birth control pills? ___Taking hormone medication?

Do you have any medical condition/disease not listed above that we should know about? NO YES

Explain_______________________________________________________________________________________________

______________________________________________________________________________________________________

## CONSENT

I attest that to the best of my knowledge, the information provided above is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next dental visit following the change. I authorize the Doctor or his representative to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations. Responsibility for payment of dental services provided in this office for my dependent(s) or myself is mine, due and payable at the time services are rendered unless other arrangements have been made in advance.

Patient's Signature_____________________________________________________ Date________________________________________

Dr. Signature____________________________________