HEALTH HISTORY

Physician's name: ______________________ Date of last visit ____________

Have you ever taken any bisphosphonates? (drug to treat Osteoporosis and other bone loss-related issues? ☐ Yes ☐ No

Mark "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding abnormally,with	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumor or Growth on	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Head or Neck	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No				Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date ____________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and correlating diagnosis:

____

____

Pharmacy name ______________________

Phone (   ) ______________________

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other

☐ Latex

UPDATES

(To be filled in at future appointments)

Has there been any changes in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications?______ If so, what? ______________________

Patient's Signature ______________________ Date ____________

Doctor's Signature ______________________ Date ____________

Has there been any changes in your health since your last dental appoinmment ☐ yes ☐ no

For what condition\?______________________

Are you taking any new medications?____________ If so , What? ______________________

Patient's signature ______________________ Date ____________

Doctor's signature ______________________ Date ____________

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date ______________________

SS# ______________________

Patient Name: ______________________
Last Name

____
First Name   Middle Initial

Address ______________________

City ______________________

State ____________ Zip Code ____________

Phone number ______________________

E-mail ______________________

Sex M ☐ F ☐ Age: ____________

Birthdate ____________ Married ☐ Single ☐

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone ______________________

____

DENTAL INSURANCE

Name of Subscriber: ______________________

Relationship to Subscriber: self ☐ spouse ☐ child ☐ other ☐

Subscriber Soc Sec: ____________ Subscriber date of Birth: ____________

Subscriber Employer ____________ Subscriber Group: # ____________

Employer Address ______________________

City, State, Zip: ______________________

Insurance Company ____________ Subscriber ID: ____________

Insurance Address ______________________

City . State, Zip ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________ ______________________ and assigned directly to
Name of Insurance Company(ies)
Dr.____________ all insurance benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Guardian or Personal Representative

____
Date: Relationship with patient

DENTAL HISTORY

Reason for today's visit ______________________

____

Former Dentist ______________________

City/State ______________________

Date of last dental visit ______________________

Date of last dental X-rays ______________________

Mark "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
Bad breath	☐	☐
Bleeding gums	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Clicking or popping jaw	☐	☐
Dry mouth	☐	☐
Fingernail biting	☐	☐
Food collection between the teeth	☐	☐
Foreign objects	☐	☐
Grinding teeth	☐	☐
Gums swollen or tender	☐	☐
Jaw pain or tiredness	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken filling	☐	☐
Mouth breathing	☐	☐
Mouth pain, brushing	☐	☐
Orthodontic treatment	☐	☐
Pain around ear	☐	☐
Periodontal treatment	☐	☐
Sensitivity to cold	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to sweets	☐	☐
Sensitivity when biting	☐	☐
Sores or growths in your mouth	☐	☐

How often do you floss? ______________________

How often do you brush? ______________________

MILANI FAMILY DENTAL
GENERAL CONSENT

I authorize Dr.Milani and her staff as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for whom I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings, dental x-rays, and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen, and drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, which may result in complications of nonhealing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: ______________________________

Signature (patient or guardian) ____________________________________ Date:_________________