Glaser Dental
24 Brown Boulevard
Rothschild, WI 54474
Phone: 715.359.4344
Fax: 715.359.7733
Email: smile@tylerglaserdental.com

Please answer all questions

Health History – Adult

Glaser Dental requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs.

No persons outside Glaser Dental will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in Glaser Dental being unable to accept you as a patient. Thank you.

_____

Patient's Name (print)

DO YOU HAVE (OR HAVE YOU HAD) ANY OF THE FOLLOWING:

	Yes	No
Allergic reaction to drugs or latex	❑	❑
(Circle all that apply) Latex Penicillin Aspirin Codeine Metal Local Anesthetics Other		
Heart attack or heart disease	❑	❑
Stroke	❑	❑
High blood pressure	❑	❑
Congestive heart failure	❑	❑
Angina	❑	❑
Heart murmer	❑	❑
Irregular heart beat	❑	❑
Heart surgery	❑	❑
Artificial heart valve	❑	❑
Rheumatic fever, rheumatic heart diseaase	❑	❑
Bacterial endocarditis (SBE)	❑	❑
Immunosuppressive condition	❑	❑
(Circle all that apply) Steroid Therapy (e.g. prednisone) Radiaton Therapy Chemotherapy SLE (Lupus) HIV Rheumatoid Arthritis Organ Transplant Spleen removed		
Artificial joints (s)	❑	❑
(Circle all that apply and date placed)		
Hip | Knee | Ankle | Shoulder | Other		
_____		
Other implants or devices	❑	❑

	Yes	No
Cancer	❑	❑
Bleeding problem, anemia, other blood disease	❑	❑
Diabetes	❑	❑
Thyroid disease	❑	❑
Nervous system disease or seizures	❑	❑
Stomach or intestinal disease	❑	❑
Kidney disease	❑	❑
AIDS	❑	❑
Hemophilia	❑	❑
Hepatitis (a, b, c or d)	❑	❑
Other liver disease	❑	❑
Arthritis (osteo or rheumatoid)	❑	❑
Other muscle or joint disease	❑	❑
Asthma	❑	❑
Tuberculosis	❑	❑
Other lung disease	❑	❑
Mental health condition – specify:	❑	❑
_____		
Physical or mental disabilities that may require special care	❑	❑
Do you have or have you ever been treated for cancer?	❑	❑
Are you or could you be pregnant?	❑	❑
Do you have difficulty hearing?	❑	❑

Please list all medications you are currently taking.

_____

_____

Are there any other conditions other than those listed above that we need to be aware of?

_____

_____

Have you ever been hospitalized or had surgery?

_____

_____

Are you, or have you ever been addicted to a chemical substance?

(examples: prescription drugs, heroin, meth, cocaine, other) _____

_____

Do you smoke or use tobacco products? _____ Are you a past user of tobacco products? _____

Do you regularly take herbal medicines or dietary supplements? Specifically do you take:

(Circle all that apply) Echinacea Garlic Ginger Kava Valerian Feverfew Gingko Ginseng St. John's Wort Vitamin E

Other: _____

Please answer all questions

Health History – Adult

Have you undergone current or past osteoporosis therapy? (*Examples are: Fosamax, Actonel, Boniva pill form)* _____

Have you undergone current or past therapy to reduce high blood calcium (bisphosphonate therapy)? _____
(Examples: intravenous Aredia, Zometa)

Physician List (please list your family physician and any medical specialists you see at least once a year):

Name	*Address*	*City*	*Phone#*	*Name of Specialty*

DENTAL HISTORY

Chief Complaint: (Why are you seeking dental care?)

_____

	Yes	No
Do you have regular dental check-ups	❑	❑
When was your last dental exam? _____		
Have you had any trouble associated with previous dental treatment?	❑	❑
Please explain: _____		
Have you noticed any lumps or sores in your mouth?	❑	❑
Do your gums bleed when you brush your teeth?	❑	❑
Has fear prevented you from seeking dental treatment?	❑	❑

	Yes	No
Have you ever injured your face, jaws or teeth?	❑	❑
Do you suffer from pain in the mouth, face, eyes, neck or throat?	❑	❑
Are you unhappy with the appearance of your teeth?	❑	❑
Are you allergic to any metals or dental materials?	❑	❑

Circle the types of dental treatment you have had:

Orthodontics (braces) *Dentures* *Root canal treatment*
Implants *Oral Surgery* *Periodontal (gum) treatment*
TMJ treatment *Crowns* *Bridges* *Veneers*
Fillings *Bleaching* *Other:* _____

AUTHORIZATION

I have reviewed the information on this questionaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status; I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I understand the use of anesthetic agents embodies a certain risk. The risks include, but are not limited to pain, swelling, bruising and permanent anesthesia.

I authorize the dentist to release all information necessary to secure payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature Date