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BECHTEL DENTISTRY

Jonathan J. Bechtel, D.D.S.

Comfortable, Comprehensive Family Dentistry

P) 517-882-7132
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Patient's Date of Birth _____

Medical History

Today's Date _____

Name ☐ Mr. ☐ Mrs. ☐ Ms. _____
First *MI* *Last*

General Health: (Check Box) ☐ Excellent ☐ Good ☐ Fair Date of last physical _____

Physician's Name _____ Phone _____

Answers to the following are for our records and are confidential.

Are you under current medical treatment? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently taking any medications or herbal supplements? ☐ Yes ☐ No

If yes, please list all prescription and non-prescription medications, including vitamins and supplements, on Medication Log.

Do you have allergies or adverse reaction to drugs? ☐ Yes ☐ No

If yes, please list drug and reaction: _____

_____

Have you ever taken I.V. or oral Bisphosphonates for bone density such as Fosamax, Actonel, Boniva, Aredia, Zometa or Bonefos? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Do you use any form of tobacco? ☐ Yes ☐ No

What Type (please circle) Cigarettes Cigars Snuff Chew How much? _____

Are you interested in quitting? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No If yes, how much per week on average? _____

Women, are you: (please circle) Pregnant Nursing On hormone therapy On birth control medication?

Do you have or have you ever had any of the following?

Rheumatic Fever	☐ yes	☐ no
Respiratory Disease	☐ yes	☐ no
Heart Murmur	☐ yes	☐ no
Intestinal Disease	☐ yes	☐ no
Heart Disease	☐ yes	☐ no
Other Heart Ailment	☐ yes	☐ no
Chemo/Radiation Therapy	☐ yes	☐ no
Mitral Valve Prolapse	☐ yes	☐ no
Cancer	☐ yes	☐ no
Artificial Joints	☐ yes	☐ no
Liver Disease	☐ yes	☐ no
HIV or AIDS	☐ yes	☐ no
Kidney Disease	☐ yes	☐ no
Venereal Disease	☐ yes	☐ no
Arthritis	☐ yes	☐ no
Hepatitis	☐ yes	☐ no
Major Operations	☐ yes	☐ no
Pacemaker	☐ yes	☐ no
Diabetes	☐ yes	☐ no
High Blood Pressure	☐ yes	☐ no
Stroke	☐ yes	☐ no
Fainting Spells	☐ yes	☐ no
Epilepsy	☐ yes	☐ no
Head Injuries	☐ yes	☐ no
Caffeine Dependency	☐ yes	☐ no
Psychological/Psychiatric Treatment	☐ yes	☐ no
Bleeding Problems	☐ yes	☐ no
Blood Transfusion	☐ yes	☐ no
Latex Sensitivity	☐ yes	☐ no
Organ Transplant	☐ yes	☐ no
Have you been told you need Antibiotics prior to dental treatment?	☐ yes	☐ no
Do you have a disease or condition not listed?	☐ yes	☐ no

If yes, please list: _____

_____

Dental History

What is your immediate dental concern?_____

Do you have dental pain now?_____

When was your last dental visit?_____

What was done at that appointment?_____

When: Was your last cleaning and exam?_____ Were your last dental x-rays taken?_____

Who was your previous dentist?_____ City_____ Phone_____

What influenced you to change dentists?_____

Are any of your teeth sensitive to hot or cold? ☐ Yes ☐ No Biting or chewing pain? ☐ Yes ☐ No

Please check if you have or have ever had:

- Unfavorable dental experiences . . . . . ☐
- Dental fears . . . . . ☐
- Preference for no dental anesthetic. . . . . ☐
- Problems with effectiveness of or bad reactions to dental anesthetic. . . . . ☐
- Orthodontic treatment (braces) . . . . . ☐
  When?_____
- Bleeding gums. . . . . ☐
- Habitual chewing of hard substances, ie: ice, popcorn kernels . . . . . ☐
- Part of your mouth is sensitive to temperature . . . ☐
- Lumps or bumps on head or neck. . . . . ☐
- Dry mouth . . . . . ☐
- Do you have a sugar or soda pop habit?. . . . . ☐
- Unpleasant taste or odor in your mouth . . . . . ☐
- Viral infection or cold sores . . . . . ☐
- Jaw problems (TMJ) . . . . . ☐
- Difficulty opening your mouth widely . . . . . ☐
- Stiff or sore head, neck or shoulder muscles . . . . ☐
- Do you wake up with tooth or jaw pain? . . . . . ☐
- Tension headaches . . . . . ☐
- Clench or grind your teeth . . . . . ☐
- Jaw clicking or popping . . . . . ☐
- Any oral appliances . . . . . ☐
- Any removable teeth . . . . . ☐
- Family history of diabetes . . . . . ☐
- Parents who have lost teeth or had gum disease . . . . . ☐
- How often do you: Brush?_____ Floss?_____
- Other oral health aids: _____
- Noticed loose teeth or a change in your bite? . . . . ☐
- Breath through your mouth while awake or asleep? . . . . . ☐

How important is it for you to keep your teeth for the rest of your life? (circle one)

Not Important 1 2 3 4 5 6 7 8 9 10 Very Important

How do you rank your smile? (circle one)

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

What would you change about your smile or bite if you could?_____

_____

What is your biggest concern about having any dental treatment?_____

_____

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of its knowledge. However, all charges for services and collection costs for untimely payments are ultimately my responsibility.

Signature (Parent's if minor) ***X***_____ Date_____