Dr. Nicolas Nieto, D.M.D., P. A.

**PATIENT MEDICAL AND DENTAL HISTORY**

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| --- |
| **Today’s Date** |
| **Patient’s Name** | | | | **Age** | | **Birth Date** | | **Social Security #** |
| **Patient’s Address** | | | | **City, State, Zip** | | | | |
| **Home Phone** | | **Work Phone** | | **Cell Phone** | | | **Email Address** | |
| **Weight** | **Height** | **Race** | **Sex** | **Where would you like us to contact you regarding your appointments?**  **Home Cell Work All** | | | | |
| **Name of Insurance** | | | | **Relation to Insured** | | | | |
| **Primary Insured’s Name** | | | | **Insured’s SS# and Date of Birth** | | | | |
| **Employer’s Name** | | | | **Spouse’s Name** | | | | |
| **Employer Address** | | | | **Spouse’s Work #** | | | | **Spouse’s Cell #** |
| **Physician’s Name** | | | | **Physician’s Number** | | | | |
| **Person to Notify in Emergency and Phone Number** | | | | | | | | |
| **How did you hear about our practice?** | | | | | **Driver’s License Number/ State ID \*REQUIRED\*** | | | |

**MEDICAL HISTORY**

**Please Circle Yes (Y) or NO (N) after the following questions:**

1. Has there been any change in your general health 7. Have you ever been hospitalized?.................................... Y N

During the past year?.............................................. Y N Reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you under a physicians care other than for 8. Women: Are you pregnant?............................................ Y N

routine physicals?................................................... Y N 9. Do you have any other condition not listed above that

1. Date of last physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may affect your treatment?............................................ Y N
2. Have you had any serious illness or operations? Y N 10. Do you smoke? How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N

Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11. Are you allergic to or have you had an adverse

1. Do you have, or have you had: reaction to:
2. Rheumatic fever or rheumatic heart disease? Y N a. Antibiotics (penicillin, sulfa, tetracycline)………………. Y N
3. Heart murmur or Mitral Valve Prolapse?........ Y N b. Sedatives or tranquilizers?......................................... Y N
4. Cardiovascular Disease (heart trouble) c. Asprin?........................................................................ Y N

Coronary artery disease, angina, stroke?....... Y N d. Codeine or other painkillers?...................................... Y N

d. High Blood Pressure?...................................... Y N e. Iodine?........................................................................ Y N

e. Hay Fever?...................................................... Y N f. Other allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

f. Sinus Trouble?................................................ Y N 12. Do you believe you maybe immunosuppressed or

g. Asthma?......................................................... Y N HIV positive?.................................................................... Y N

h. Hepatitis, Jaundice, Liver Disease?................. Y N 13. Are you taking any medication that may affect your

i. Arthritis?........................................................ Y N immune system?.............................................................. Y N

j. Fainting Spells or Seizures (Epilepsy)?........... Y N 14. Do you have Glaucoma?................................................... Y N

k. Diabetes?....................................................... Y N 15. Have you had a prolonged fever, coughing blood, or

l. Ulcers?.......................................................... Y N chest pain?....................................................................... Y N

m. Kidney or Bladder Disease?........................... Y N 16. Are you using any of the following?

n. Low Blood Pressure?..................................... Y N a. Antibiotics or sulfa drugs?........................................... Y N

o. Thyroid Condition?........................................ Y N b. Anticoagulants (blood thinners)?................................. Y N

p. Anemia or Other Blood Disorder?................. Y N c. High blood pressure medicines?................................... Y N

q. Cancer, Chemotherapy, or Radiation?.......... Y N d. Heart medications (Digitalis, Inderal, Nitroglycerin)? Y N

r. Artificial Joint/Implants?............................... Y N e. Steroids (Cortisone, ect.)?............................................. Y N

s. Emphysema?................................................. Y N f. Birth Control Pills?.......................................................... Y N

t. Tuberculosis?................................................ Y N g. Insulin or diabetic drugs?.............................................. Y N

6. Do you bruise easily or have prolonged bleeding? Y N

\*List Medications or Drugs you are currently taking below. Attach separate sheet if necessary.

|  |  |  |
| --- | --- | --- |
| Medication | Indication | Side Effects |
|  |  |  |
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**Please Circle Yes (Y) or NO (N) after the following questions:**

1. Have you ever been diagnosed with or treated for Osteoporosis or Osteopenia? Y N
2. Have you ever taken any of these medications?

Etdronate(Didronel) Y N

Tiludronate (Skelid) Y N

Alendronate (Fosamax) Y N

Risedronate (Actonel) Y N

Ibandronate (Boniva) Y N

Pamidronate (Aredia) Y N

Zoledronate (Zometea) Y N

1. Have you ever received chemotherapy (I.V. or oral) Y N

**Women**

Have you ever been diagnosed with or treated for multiple myeloma or breast cancer? Y N

**Men**

Have you ever been diagnosed with or treated for multiple myeloma or prostate cancer? Y N

*If you answered yes to any of the above questions, please give physicians information.*

Name and number of Primary M.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and number of Oncologist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle Yes (Y) or NO (N) after the following questions:**

1. Do you have problems with you TMJ (jaw joint)…………………………………………… Y N
2. Are any of your teeth sensitive to cold, heat, or sweets?.................................. Y N
3. Have you had any serious trouble associated with previous treatment?.......... Y N
4. Do your gums bleed when you brush your teeth?............................................. Y N
5. Do you have pain in or near your ears?.............................................................. Y N
6. Do you have any injuries or inflamed areas in your mouth?.............................. Y N
7. Have you experienced any growths or sore spots in your mouth?.................... Y N
8. Have you ever had Novocaine anesthetic?........................................................ Y N
9. Any reactions or allergic symptoms to Novocaine?........................................... Y N
10. Any difficult extractions in the past?................................................................. Y N
11. Prolonged bleeding following extractions in the past?..................................... Y N
12. Do you have any dental complaints presently?................................................. Y N

If so specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When was your last full dental examination?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When was your last full mouth x-ray taken?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. When was your last dental cleaning?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

I am aware that payment is due at the time of service, and methods of payment include Cash, Check, Mastercard, Visa, Discover, and American Express.

I hereby certify that the above information is true and, in addition, authorize Dr. Nicolas Nieto and staff under his direction to perform dental/oral surgical procedures to restore and/or preserve my overall dental/oral health. I am aware that if I do not give 24 hour notice for cancellation, I will be charged a fee of $25 per half hour. I have received and signed the office’s Notice of Privacy Practices.

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Signature (patient or parent if minor) Date

**For Doctor’s Use Only**

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| EVALUATION OF MEDICAL HISTORY |

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| --- | --- | --- |
| DATE | SIGNATURE | ASSESSMENT/REASSESSMENT |
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