Family Dentistry
of Northwest Ohio

DRS. COUSINO, PINTER AND ROTH MEDICAL HISTORY FORM

PATIENT INFORMATION TODAY'S DATE_____

LAST NAME_____ FIRST NAME_____ M.I._____

CIRCLE ONE: SINGLE☐ MARRIED☐ DIVORCED☐ WIDOWED☐ SEPERATED☐

WHAT DO YOU PREFER TO BE CALLED? EXAMPLE: ROBERT (BOB)_____

MALE☐ FEMALE☐ BIRTHDATE_____AGE_____SOC. SEC.#_____E-MAIL_____

STREET_____CITY_____STATE_____ZIP_____

CELL (_____)_____HOME (_____)_____WORK PHONE (_____)_____

EMPLOYER: _____EMPLOYER'S ADDRESS _____

HOW LONG WORKED THERE? _____OCCUPATION:_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

OTHER FAMILY MEMBERS SEEN BY US_____

PREVIOUS DENTIST:_____LAST VISITDATE:_____

IN CASE OF EMERGENCY, PLEASE
CONTACT_____TEL(_____)_____RELATION_____

SPOUSE INFORMATION:

HIS/HER NAME: _____ EMPLOYER: _____

WORK PHONE(_____)_____ BIRTHDATE_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

SELF☐ (IF SELF, SKIP THIS SECTION) SPOUSE☐ FATHER☐ MOTHER☐ OTHER☐

NAME_____ S.S.#_____ BIRTHDATE_____AGE_____

CELL (_____) _____ TEL. (_____)_____E-MAIL_____

STREET ADDRESS _____

EMPLOYER_____ BUS. TEL.(_____)_____

INSURANCE INFORMATION:

MARITAL STATUS: MARRIED☐ DIVORCED☐ WIDOW☐ SINGLE☐ LEGALLY SEPARATED☐

EMPLOYED: FULL TIME☐ PART TIME☐ RETIRED☐ NOT☐

PRIMARY DENTAL INSURANCE COMPANY:

INSURED PARTY_____

RELATIONSHIP_____ **SEX: MALE**_____**FEMALE**_____ **BIRTHDATE**_____ **S.S.#**_____

PLAN _____

EMPLOYER NAME _____

INSURANCE COMPANY _____

INSURANCE COMPANY CLAIM ADDRESS _____

IDENTIFICATION # _____ **GROUP #** _____

SECONDARY DENTAL INSURANCE COMPANY:

INSURED PARTY_____

RELATIONSHIP_____ **SEX: MALE**_____**FEMALE**_____ **BIRTHDATE**_____ **S.S.#**_____

PLAN _____

EMPLOYER NAME _____

INSURANCE COMPANY _____

INSURANCE COMPANY CLAIM ADDRESS _____

IDENTIFICATION # _____ **GROUP #** _____

DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY? _____

ARE YOU CURRENTLY IN PAIN? YES NO

HAVE YOU EVER HAD A SERIOUS/DIFFICULT PROBLEM WITH ANY PREVIOUS DENTAL WORK? _____

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN/DISCOMFORT IN YOUR JAW JOINT (TMJ)? YES NO

YOUR CURRENT DENTAL HELATH IS: GOOD FAIR POOR

DO YOUR GUMS EVER BLEED? YES NO HOW MANY TIMES A WEEK DO YOU FLOSS? _____ A DAY YOU BRUSH? _____

HEALTH HISTORY

HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE CARE THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

1. HEIGHT`_____ WEIGHT_____ ARE YOU IN GOOD HEALTH? YES NO
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH IN THE PAST YEAR? YES NO
3. ARE YOU UNDER THE CARE OF A PHYSICAN? _____DATE OF LAST VISIT_____
   IF SO, WHAT ARE YOU BEING TREATED FOR? _____
4. HAVE YOU HAD ANY ILLNESS, OPERATION OR BEEN HOSPITALIZED IN THE PAST FIVE YEARS?
   _____
5. DO YOU HAVE A PROTHETIC JOINT/IMPLANT? IF SO, DESCRIBE WHERE_____
6. HAVE YOU HAD A HEART VALVE REPLACEMENT OR VASCULAR GRAFT? _____
7. HAVE YOU EVER HAD GENERAL ANESTHESIA? _____
8. HAVE YOU, OR A FAMILY MEMBER, HAD ANY UNUSUAL OR SERIOUS REACTIONS TO GENERAL ANESTHESIA?
   _____
9. HAVE A PHYSICIAN OR PREVIOUS DENTIST RECOMMENDED THAT YOU TAKE ANTIBOTICS PRIOR TO YOUR DENTAL TREATMENT?
   _____

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
10. HEART CONDITION		
11. HIGH BLOOD PRESSURE		
12. CHEST PAIN/ANGINA		
13. HEART ATTACK (S)		
14. EMPHYSEMA/COPD		
15. SINUS PROBLEMS		
16. ASTHMA/BREATHING PROBLEMS		
17. SNORING/SLEEP APNEA/CPAP		
18. TUBERCULOSIS		
19. BLOOD DISORDER SUCH AS ANEMIA		
20. BLEEDING TENDENCY/ABNORMAL BLEEDING		
21. HEPATITIS, JAUNDICE, OR LIVER DISEASE		
22. FAINTING SPELLS		
23. SEIZURES		
24. STROKE		
25. THYROID TROUBLE		
26. DIABETES		
27. KIDNEY TROUBLE		
28. ARE YOU ON DIALYSIS		
29. ARTHRITIS/JOINT DISEASE		
30. OSTEOPOROSIS/OSTEOPENIA		
31. STOMACH/ACID REFLUX		
32. SEXUALLY TRANSMITTED DISEASES		
33. CANCER/RADIATION THERAPY/CHEMOTHERAPY		
34. DO YOU SMOKE OR VAPE IF SO, HOW MUCH A DAY?		
35. A HISTORY OF ALCOHOL/SUBSTANCE ABUSE		
36. A HISTORY OF MARIJUANA OR OTHER DRUG USE		
37. EYE DISEASE/GLAUCOMA		
38. MENTAL HEALTH PROBLEMS/ANXIETY/DEPRESSION		
39. PAIN OR CLICKING OF JAWS WHEN EATING		
ARE YOU NOW TAKING	YES	NO
40. ANY KIND OF MEDICATION, DRUG, PILLS?		
41. BLOOD THINNERS, (COUMADIN, PLAVIX, ASPIRIN, VITAMIN E, GINKO BILOBA, AGGRENOX, XARELTO, ELIQUIS, FISH OIL)?		
42. ANY NATURAL PRODUCT, HERBAL SUPPLEMENT OR HOMEOPATHIC REMEDY?		
43. ARE YOU TAKING, OR HAVE YOU EVER TAKEN BONE DENSITY MEDS, RANKL INHIBITORS, OR BISPHOSPHONATES, SUCH AS PROLIA, FOSAMAX, BONIVA, ACTONEL, IV-ZOMETA, AREDIA, RECLAST, XGEVA, OR EVISTA IN THE PAST 12 YEARS?		
44. IF YOU ARE UNDER THE CARE OF A PHYSICIAN FOR PAIN MANAGEMENT, OR RECOVERING FROM DRUG ADDICTION PLEASE CIRCLE THE MEDICATION YOU ARE CURRENTLY TAKING: METHADONE SUBOXONE OXYCODONE FENTANYL OTHER NAME OF TREATING DOCTOR		
45. PHARMACY NAME		
46. PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: MEDICATION	DOSAGE	FREQUENCY

WOMEN ONLY: QUESTIONS 47-49

47. IS THERE A POSSIBILITY OF PREGNANCY Y☐ N☐

48. EXPECTED DELIVERY DATE?_____

49. ARE YOU NURSING? Y☐ N☐

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO
50. LOCAL ANESTHETIC (NUMBING MEDS) ?	☐	☐
51. PENICILLIN/AMOXICILLIN?	☐	☐
52. OTHER ANTIBIOTICS?	☐	☐
53. SULFA DRUGS?	☐	☐
54. CODEINE OR OTHER NARCOTICS?	☐	☐
55. LATEX?	☐	☐
56. EGGS/YOLK?	☐	☐
57. PLEASE LIST ANY OTHER ALLERGIES:	☐	☐

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ Signature of patient (Parent or Guardian if minor)

I authorize Drs. Cousino, Pinter and Roth to contact me in the following manner (check all that apply)

By Mobile phone (_____)_____

Please leave a message with detailed info☐ Please leave a message with a call back number☐
Please send a text with detailed information☐ Please send a text with a call back number☐

By Home phone (_____)_____

Please leave a message with detailed info ☐ Please leave a message with a call back number☐

By e-mail address_____

Please e-mail a message with detailed info☐ Please e-mail a message with a call back number☐

I authorize Drs. Cousino, Pinter and Roth to discuss my private health information with the following (check all that apply):

Spouse (first and last name)_____

Adult Child(ren) (first and last name)_____

Parents (first and last name)_____

Person representative (first and last name)_____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR) _____ DATE_____

I HEARBY ACKNOWLEDGE THAT A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK

ANY QUESTIONS I MAY HAVE REGARDING THIS NOTICE._____SIGNATURE AND DATE_____