Jared S. Percyz, D.D.S.
27 Meriden Ave.
Southington, CT 06489
628-5531

Medical History Form

Date _____

Patient Name _____ (Last / First / Middle) Date of Birth ____/____/____ (mo. / day / year)

Address _____ (Number, Street)

City _____ State _____ Zip Code _____

Occupation _____ Name of Spouse _____

If you are completing this form for another person, what is your relationship to that person? _____

For the following questions, *circle yes or no,* whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
   _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
   If so, what medicine(s) are you taking? _____
8. Are you allergic or have you had a reaction to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Aspirin ..... Yes No
   e. Iodine ..... Yes No
   f. Codeine or other narcotics ..... Yes No
   g. Other _____
9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Tuberculosis	YES	NO
Heart Disease or Attack	YES	NO	Asthma	YES	NO
Angina Pectoris	YES	NO	Hay Fever	YES	NO
Congenital Heart Disease	YES	NO	Allergies or Hives	YES	NO
Heart Murmur	YES	NO	Sinus Trouble	YES	NO
High Blood Pressure	YES	NO	Radiation Therapy	YES	NO
Arteriosclerosis	YES	NO	Chemotherapy	YES	NO
Mitral Valve Prolapse	YES	NO	Hepatitis A (Infectious)	YES	NO
Artificial Heart Valve	YES	NO	Hepatitis B (serum)	YES	NO
Heart Pacemaker	YES	NO	Venereal Disease	YES	NO
Heart Surgery	YES	NO	A.I.D.S.	YES	NO
Rheumatic Fever	YES	NO	H.I.V. Positive	YES	NO
Arthritis	YES	NO	Cold Sores/Fever Blisters	YES	NO
Rheumatism	YES	NO	Blood Transfusion	YES	NO
Drug Addiction	YES	NO	Hemophilia	YES	NO
Stroke	YES	NO	Anemia	YES	NO
Artificial Joints (hips, knee, etc)	YES	NO	Sickle Cell Disease	YES	NO
Kidney Trouble	YES	NO	Bruise Easily	YES	NO
Ulcers	YES	NO	Liver Disease	YES	NO
Diabetes	YES	NO	Yellow Jaundice	YES	NO
Thyroid Problems	YES	NO	Epilepsy or Seizures	YES	NO
Glaucoma	YES	NO	Fainting or Dizzy Spells	YES	NO
Cosmetic Surgery	YES	NO	Nervousness	YES	NO
Emphysema	YES	NO	Latex Allergy	YES	NO
Chronic Cough	YES	NO			

Over

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? . . . . . Yes No
11. Do your ankles swell during the day? . . . . . Yes No
12. Are you short of breath after mild exercise or while lying down? . . . . . Yes No
13. Are you on a special diet? . . . . . Yes No
14. Have you ever had cancer, a tumor or a growth? . . . . . Yes No
15. Do you have or have you had any disease, condition, or problem not listed? . . . . . Yes No

If yes, please list: _____

_____

FOR WOMEN ONLY:

Are you pregnant? ❑ No ❑ Yes, what month? _____ Are you nursing?

Are you taking birth control pills? ❑ Yes ❑ No Are you currently taking any antibiotics? ❑ Yes ❑ No

I understand the information on the front of this sheet is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge: I also understand that it is my responsibility to inform the office of any changes in my health or any difference in my medication since my last visit.

Patient Signature _____ Date _____

DENTAL HISTORY

1) DO YOU HAVE ANY PROBLEMS OR CONCERNS WITH ANY OF YOUR TEETH AT THIS TIME? IF YES, PLEASE EXPLAIN. _____

_____

_____

2) WHEN WAS YOUR LAST DENTAL CLEANING? _____
3) WHEN WAS THE LAST TIME YOU HAD DENTAL X-RAYS TAKEN? _____
4) HAVE YOU EVER HAD ORTHODONTIC TREATMENT? _____
5) HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE? _____
6) DO YOU GUMS BLEED WHEN YOU BRUSH OR FLOSS YOUR TEETH? _____
7) WHAT ORAL HYGIENE AIDS ARE YOU PRESENTLY USING? _____

(I.E., TOOTHBRUSH, MOTORIZED TOOTHBRUSH, FLOSS, STIMUDENTS, PROXABRUSH, SUPERFLOSS, FLOSS THREADERS, HOME FLUORIDE, TARTAR CONTROL TOOTHPASTE, BAKING SODA TOOTHPASTE?) _____

_____

8) DO YOU CLENCH OR GRIND YOUR TEETH? _____
9) DO YOU GET FREQUENT HEADACHES? _____
10) DOES YOUR DRINKING WATER CONTAIN FLUORIDE? _____
11) IS THERE ANYTHING ABOUT THE APPEARANCE OF YOUR TEETH THAT YOU WOULD LIKE TO CHANGE?

_____

_____

12) HAVE YOU EVER HAD ANY PROBLEMS ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT? _____

_____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all recommended treatment and to use the appropriate medication and therapy indicated for such treatment in Connecticut with (Name of Patient) _____ I understand that using anesthetic agents embodies a certain risk, and I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand that the office reserves the right to charge for appointments cancelled or broken without 24 hours advance notice, and that I am responsible for any charges for services rendered and balances not covered by insurance.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____