HAZELTON
FAMILY DENTISTRY
Zachary Hazelton, D.D.S
677 Anne St NW *Suite F*
Bemidji, MN 56619

Mailing Address: PO Box 397 Bemidji, MN 56619
Phone: (218) 333-8668 **Fax:** (218) 333-1515
www.hazeltonfamilydentistry.com

MEDICAL HISTORY

Name of Patient _____ Sex _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone: _____ May we call you at work? ○ Yes ○ No

Birth Date _____ S.S.# _____ Marital Status _____ Spouse Name, if married _____

Parent's names, if patient is a minor _____ School _____

PARENT'S EMAIL _____ **PATIENT'S** EMAIL _____

Referred By: ☐ *Family/Friend* ☐ *Internet/Website* ☐ *Phone Book* ☐ *Other*

Patient employed by _____ Spouse employed by _____

Name of **Party Responsible** for this account: _____

Address of **Responsible Party**, (*if different from patient's*): _____

Responsible Party Employed by: _____

If on Medical Assistance or Minnesota Care, please give **MA** number: _____

Name and Address of Insurance Company, if you have coverage: _____

_____

Policy Holder Name, Employer, DOB and S.S#: _____

_____

Secondary Policy Holder Name, Employer, DOB and S.S#: _____

_____

Emergency Contact: _____

DENTAL INFORMATION

Reason for your visit: _____

Yes	No	
○	○	1) Do you supplement your diet with fluoride?
○	○	2) Are you having dental pain?
○	○	3) Have you had: Orthodontic Treatment?
○	○	Oral Surgery?
○	○	Gum Disease?
○	○	Worn a bite plane or other appliance?
○	○	4) Does food tend to get caught between your teeth?
○	○	5) Do your gums often bleed when you brush?
○	○	6) Are you dissatisfied with the function of your teeth?
○	○	7) Have you had any head, neck or jaw injuries?
○	○	8) Do you supplement your diet with fluoride?
○	○	9) Does anything about having dental treatment bother you?

Yes	No	
○	○	10) Concerning your jaw, have you ever experienced:
○	○	a. Clicking of the jaw?
○	○	b. Joint, ear or face pain?
○	○	c. Difficulty in opening or closing?
○	○	d. Difficulty in chewing?
○	○	11) Concerning habits, do you:
○	○	a. Clench or grind your teeth?
○	○	b. Bite your lips or cheeks?
○	○	12) Have you ever had a bad experience in a dental office?
○	○	13) Is it important to you to keep your teeth?
○	○	14) Are you dissatisfied with the appearance of your teeth?

If so, what would you change? _____

If you answered "**YES**" to any of the above, please explain: _____

_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Yes	No	
○	○	Are you under a physician's care now? *If yes, please explain:* _____
○	○	Have you ever been hospitalized or had a major operation? *If yes, please explain:* _____
○	○	Have you ever had a serious head or neck injury? *If yes, please explain:* _____
○	○	Are you taking any medications, pills, or drugs? *If yes, please explain:* _____
○	○	Do you take, or have you take, Phen-Fen or Redux?
○	○	Are you on a special diet?
○	○	Do you use tobacco?
○	○	Do you use controlled substances?

Women: Are you pregnant or trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ *Aspirin* ☐ *Penicillin* ☐ *Codeine* ☐ *Acrylic* ☐ *Metal* ☐ *Latex* ☐ *Local Anesthetics* ☐ *Sulfa drugs*

☐ *Other, please explain:* _____

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

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	○	○	Cortisone Medicine	○	○	Hemophilia	○	○	Radiation Treatments	○	○
Alzheimer's Disease	○	○	Diabetes	○	○	Hepatitis A	○	○	Recent Weight Loss	○	○
Anaphylaxis	○	○	Drug Addiction	○	○	Hepatitis B or C	○	○	Renal Dialysis	○	○
Anemia	○	○	Easily Winded	○	○	Herpes	○	○	Rheumatic Fever	○	○
Angina	○	○	Emphysema	○	○	High Blood Pressure	○	○	Scarlet Fever	○	○
Arthritis/Gout	○	○	Epilepsy or Seizures	○	○	High Cholesterol	○	○	Shingles	○	○
Artificial Heart Valve	○	○	Excessive Bleeding	○	○	Hives or Rash	○	○	Sickle Cell Disease	○	○
Artificial Joint	○	○	Excessive Thirst	○	○	Hypoglycemia	○	○	Sinus Trouble	○	○
Asthma	○	○	Fainting Spells/Dizziness	○	○	Irregular Heartbeat	○	○	Spina Bifida	○	○
Blood Disease	○	○	Frequent Cough	○	○	Kidney Problems	○	○	Stomach/Intestinal Disease	○	○
Blood Transfusion	○	○	Frequent Diarrhea	○	○	Leukemia	○	○	Stroke	○	○
Breathing Problem	○	○	Frequent Headaches	○	○	Liver Disease	○	○	Swelling of Limbs	○	○
Bruise Easily	○	○	Genital Herpes	○	○	Low Blood Pressure	○	○	Thyroid Disease	○	○
Cancer	○	○	Glaucoma	○	○	Lung Disease	○	○	Tonsillitis	○	○
Chemotherapy	○	○	Hay Fever	○	○	Mitral Valve Prolapse	○	○	Tuberculosis	○	○
Chest Pains	○	○	Heart Attach/Failure	○	○	Osteoporosis	○	○	Tumors or Growths	○	○
Cold Sores/Fever Blisters	○	○	Heart Murmur	○	○	Pain in Jaw Joints	○	○	Ulcers	○	○
Congenital Heart Disorder	○	○	Heart Pace Maker	○	○	Parathyroid Disease	○	○	Venereal Disease	○	○
Convulsions	○	○	Heart Trouble/Disease	○	○	Psychiatric Care	○	○	Yellow Jaundice	○	○

Have you ever had any serious illness not listed about? ○ Yes ○ No *If yes, please explain:* _____

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions of this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE _____