GORDON GEICK DMD
Family & Cosmetic Dentistry

MEDICAL HISTORY

Patient name :_____
Physician's Name: _____ Phone Number: _____
Address: _____ Date of last exam: _____

Have you had any serious health problems in the last five years? ……..... yes____ no____
If yes, please explain: _____

(For women) Are you currently pregnant? …….. yes____ no____ If yes, how many months?_____

Please list prescription and non-prescription medications you are taking: _____
_____
_____

Please check if you are allergic to any of the following:

- □ Local anesthetics
- □ Penicillin / other antibiotics
- □ Barbiturates, sedatives, sleeping pills
- □ Other _____
- □ Sulfa Drugs
- □ Aspirin
- □ Iodine
- □ Codeine / other narcotics
- □ Latex
- □ Any metals (nickel, mercury, etc.)

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

- □ Alzheimer's Disease
- □ Anemia
- □ Arthritis / Gout
- □ Artificial Heart Valve
- □ Artificial Joint
- □ Asthma
- □ Blood Disease
- □ Blood Transfusion
- □ Breathing Problem
- □ Bruise Easily
- □ Cancer
- □ Chemotherapy
- □ Chest Pains
- □ Cold Sores/Fever Blisters
- □ Congenital Heart Disorder
- □ Convulsions
- □ Cortisone Medicine
- □ Diabetes
- □ Drug Addiction
- □ Easily Winded
- □ Emphysema
- □ Epilepsy / Seizures
- □ Excessive Bleeding
- □ Excessive Thirst
- □ Fainting Spells / Dizziness
- □ Frequent Cough
- □ Frequent Diarrhea
- □ Frequent Headaches
- □ Glaucoma
- □ Hay Fever / Allergies
- □ Heart Attack / Failure
- □ Heart Murmur
- □ Heart Pacemaker
- □ Heart Trouble / Disease
- □ Hemophilia
- □ Hepatitis A, B, or C
- □ High Blood Pressure
- □ High Cholesterol
- □ HIV Positive / AIDS
- □ Hives / Rash
- □ Hypoglycemia
- □ Irregular Heartbeat
- □ Jaundice
- □ Kidney Problems
- □ Leukemia
- □ Liver Disease
- □ Low Blood Pressure
- □ Lung Disease
- □ Mitral Valve Prolapse
- □ Psychiatric Care
- □ Radiation Treatments
- □ Recent Weight Loss
- □ Renal Dialysis
- □ Rheumatic Fever
- □ Rheumatism
- □ Scarlet Fever
- □ Sexually Transmitted Disease
- □ Shingles
- □ Sickle Cell Disease
- □ Sinus Trouble
- □ Stomach Trouble
- □ Stroke
- □ Thyroid Disease
- □ Tonsillitis
- □ Tuberculosis
- □ Tumors or Growths
- □ Ulcers

Have you ever had any serious illness not listed above? If yes, please explain: _____
_____

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? …… yes____ no____
Do you snore or have you been told in the past that you snore? …… yes____ no____
Do you regularly have excessive daytime sleepiness? …… yes____ no____
Have you been diagnosed with sleep apnea? …… yes____ no____
Is there a history of heart disease in your immediate family? …… yes____ no____
Do you have a family history of Diabetes? …… yes____ no____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient (or parent/guardian if minor) Date

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DENTAL HISTORY

Name and location of previous dentist _____
When was your most recent dental visit? _____

Do your gums bleed while brushing or flossing?	yes____	no____
Are your teeth sensitive to hot or cold liquids/foods?	yes____	no____
Are your teeth sensitive to sweet or sour liquids/foods?	yes____	no____
Do you feel pain to any of your teeth?	yes____	no____
Are any of your teeth loose?	yes____	no____
Have your gums receded (do teeth look longer)?	yes____	no____
Are your gums sore or swollen?	yes____	no____
Do you have any sores or lumps in or near your mouth?	yes____	no____
Do you have unexplained numbness or pain in the face/neck/mouth?	yes____	no____
Do you have chronic hoarseness?	yes____	no____
Do you have persistent sore throat / ear pain?	yes____	no____
Do you have difficulty swallowing?	yes____	no____
Do you bite your lips or cheeks frequently?	yes____	no____
Do you smoke or use tobacco products?	yes____	no____
Do you drink excessively?	yes____	no____
Have you had any head, neck or jaw injuries?	yes____	no____
Do you have frequent headaches?	yes____	no____
Do you clench or grind your teeth?	yes____	no____
Have you ever experienced any of the following problems in your jaw?		
Clicking	yes____	no____
Pain (joint, ear, side of face)	yes____	no____
Difficulty in opening or closing	yes____	no____
Difficulty in chewing	yes____	no____
Have you ever had any difficult extractions in the past?	yes____	no____
Have you ever had any prolonged bleeding following extractions?	yes____	no____
Have you had orthodontic treatment?	yes____	no____
Do you wear dentures or partials?	yes____	no____
If yes, date of placement_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	yes____	no____
Do you like your smile?	yes____	no____

How often do you brush your teeth? _____
How often do you floss your teeth? _____

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PATIENT INFORMATION

Today's date: _____

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the total health and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible. Thank you!

For your convenience we offer the following forms of payment: cash, personal check, Visa, Master Card and Care Credit.

ABOUT YOU

Name: _____ □ Female □ Male
Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Email address: _____
Birth date: _____/_____/_____ Marital status: _____
Social Security Number: _____
Who may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____
Relationship to patient: _____
Birth date: _____/_____/_____ Social Security Number: _____
Is this person currently a patient in our office? _____

EMERGENCY INFORMATION

Person to contact: _____
Relationship: _____
Phone: _____

INSURANCE INFORMATION

Insurance company name: _____
Group #: _____
ID/Social Security #: _____
Employer: _____
Employer address: _____
If spouse is your policy holder:
Spouse's name: _____
Spouse's birth date: _____/_____/_____ Spouse's SS#: _____
Spouse's employer: _____

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advance notice of two business days.** We understand that conflicts arise; however, failing your appointment or canceling without adequate notice multiple times will result in a required pre-payment and then discontinuation of services.
Initials: _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I understand that my dental insurance is my financial responsibility. I authorize release of information relating to this claim and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

_____
Signature