ANDRÉ J. BÉRUBÉ D.M.D.
Family and Cosmetic Dentistry

CONFIDENTIAL MEDICAL - DENTAL HISTORY

Patient's Name _____ DOB: / / *INSURANCE/SSN:* _____ M/F

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

MEDICAL HISTORY

- Write the answer to each question in the space provided.
- If the question is not understood, you are not certain of the answer, or have any questions, indicate so in the space, and discuss the matter with the doctor.
- All questions must be answered.
- Use black ink or ball point pen.

Name of Physician (medical doctor): _____ Phone _____

Address _____

Date of last visit _____ Reason for last visit _____

1. Do you consider yourself in good health now? _____
2. Are you currently under the care of a physician? If yes, for what reason or condition? _____
3. Are you currently taking any medication? (prescribed or illicit drugs)? _____
   List: _____
4. Have you taken cortisone or steroids in the last year? Cocaine? _____
5. **Have You Ever Had Or Been Treated For:**
   A. Rheumatic fever, Rheumatic heart disease, Heart murmur, or Congenital heart disease? _____
   B. Mitral valve prolapse, Artificial heart valves or joints? _____
   C. Heart attack, Angina, Heart surgery, a Pacemaker, Irregular beats, or other heart ailment? _____
   D. Pain in chest, Shortness of breath, Swollen ankles, or Numbness? _____
   E. Stomach, Intestinal disease, or Ulcers? _____

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F. Glaucoma, Abnormal blood pressure, Excessive bleeding, Anemia, or Blood transfusion? _____

H. Breathing problems, Bronchitis, Asthma, Tuberculosis, Hay fever, or Sinus? _____

H. Cancer, X-ray treatments, or Chemotherapy? _____

I. Diabetes, Thyroid? _____

J. Hepatitis, Jaundice, or Liver disease? _____

K. Kidney problems or Renal dialysis? _____

L. Venereal disease, AIDS/HIV/ARC, or Herpes? _____

M. Stroke, Convulsions, Epilepsy, Fainting spells, or Seizures? _____

N. Tumors or Growths? _____

O. Arthritis or Rheumatism? _____

P. Allergic reactions to medications or ill effect from:

_____ Penicillin	_____ Erythromycin	_____ Novocaine
_____ Codeine	_____ Tetracycline	_____ Xylocaine
_____ Sulfa	_____ Amoxyllin	_____ Local Anesthetic
_____ Aspirin	_____ Eugenol (Cloves' Flavor)	
_____ Tylenol	_____ Iodine	
_____ Fluoride	_____ Formaldehyde	
_____ Nickel / Chrome	_____ Sulfite / Preservatives	
_____ Latex / Rubber	_____ Acrylic / Plastic	
_____ Talc / Powder	_____ Bleach	

or other: _____

6. Have you ever had a serious injury to your head or neck? If yes, describe: _____

_____

7. Do you use more than two pillows to sleep? _____

8. Have you ever had a major operation? If yes, describe. _____

_____

9. Are you on a special diet? If yes, for what reasons and describe. _____

_____

9A. Have you ever taken "FEN-PHEN" pills? _____

9B. Have you ever taken FOSAMAX or similar medication for bone-loss prevention? _____

10. Do you smoke or dip tobacco? If yes, describe type and quantity. _____

11. Have you consulted or been treated by a psychiatrist, psychologist or counsellor? If yes, describe. _____

_____

12. Are there any other problems about your health of which you are aware? _____

_____

13. For WOMEN:
- Are you pregnant or suspect you may be? _____
- Nursing? _____
- Are you taking birth control pills? _____

NOTE: A Change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission to Release Health Information:

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners.

Person completing the form: Signature **X** _____ Date _____ / _____ / _____

Print Name: _____

If other than patient, indicate relationship: _____

Who may we thank for referring you? _____

_____

DOCTOR'S USE ONLY

Dentist's History Review & Significant Findings

_____

_____

_____

_____

_____

_____

_____

B.P.s: _____ /d: _____

Nitro in: _____

Contact lens ( )

Medical ALERT

Signature Dr. _____ Date _____

REVIEWED on – _____ / _____ / _____ _____ Dr _____

REVIEWED on – _____ / _____ / _____ _____ Dr _____

REVIEWED on – _____ / _____ / _____ _____ Dr _____

REVIEWED on – _____ / _____ / _____ _____ Dr _____

Please turn to last page

DENTAL HISTORY

Date of your last visit to a dentist _____

Former dentist name: _____

Reason for your last visit (or series of visits) _____

Do you have any of your X-rays or dental records? _____

When were your last full mouth X-rays taken? _____

14. In respect to any previous dental treatment have you:

A. Ever fainted? _____

B. Had an allergic reaction? _____

C. Had abnormal bleeding? _____

D. Any other complications during or following dental treatment? ____ If yes, describe: _____

_____

15. Do your gums bleed when brushing or eating? _____

16. Does food get caught between your teeth? _____

17. Have your teeth shifted? _____ Are there spaces between your teeth now where there were none? _____ Are your teeth flaring?(protruding) _____ Are some of your teeth becoming loose? _____

18. Are any of your teeth sensitive to heat, cold, or pressure? _____

19. Do you grind your teeth or clench your jaws? _____

20. Do you have pain or clicking in the jaw joint around your ear? _____

21. Have your jaw muscles ever been sore? If yes, describe. _____

_____

22. Are there any sores or growths in your mouth? _____

23. Do any of your teeth hurt? _____

24. Have you ever had periodontal therapy (gum surgery)? _____

25. Have you ever had a local anesthetic? (eg. Novocaine) _____

26. Do you have any other dental complaints? _____

EMERGENCY INFORMATION

Person to contact in case of emergency _____

Complete Address _____

Phone _____

PATIENT INFORMATION FORM

NAME (Last, First, Middle): _____ , _____ , _____ Mr./Mrs./Miss/Dr./: _____

HOME ADDRESS: _____
Street City State Zip Code

PREFERED NAME: _____ INSURANCE / SS NO: _____ DOB: _____ /_____ /_____

HOME PHONE: _____ MARITAL: S / M / D / W REFERRING DOCTOR: _____

WORK PHONE: _____ CELL: _____ SEX: M / F REFERRING PATIENT: _____

EMPLOYER: _____ POSITION: _____ SPOUSE NAME: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

INSURANCE / SS NO: _____ EMPLOYER: _____

DOB: _____ /_____ /_____ ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

INSURANCE CO: _____ IND YRLY DEDUCT: _____

ADDRESS: _____ FAM YRLY DEDUCT: _____

ADDITIONAL DENTAL INSURANCE COVERAGE

SECONDARY SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

INSURANCE / SS NO: _____ EMPLOYER: _____

DOB: _____ /_____ /_____ ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

INSURANCE CO: _____ IND YRLY DEDUCT: _____

ADDRESS: _____ FAM YRLY DEDUCT: _____

MEDICAL INSURANCE COVERAGE (For Accidents, etc..)

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

PLAN NAME: _____ GROUP NO: _____

RESPONSIBLE PARTY:

Name and Address: _____

Work Phone #: _____

I authorize and request my insurance company to pay directly to Dr. A. Bérubé insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and may as well have a different percentage of coverage than estimated or reject payment even against agreed predetermination. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____