MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No Physician's Name: ______

Phone #: ______ Date of last visit: ______

Your current physical health is ☐ Good ☐ Fair ☐ Poor Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No Please explain: ______

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No Please list each one: ______

For women: Are you taking birth control pills? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Week #: ______ Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems? (PLEASE CIRCLE)

Y	N	Anemia / Radiation Treatment	Y	N	Emphysema / Glaucoma	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints	Y	N	Epilepsy / Seizures / Fainting Spells	Y	N	Kidney Problems
Y	N	Artificial Valves	Y	N	Fever Blisters / Herpes	Y	N	Mitral Valve Prolapse
Y	N	Asthma / Arthritis	Y	N	Heart Attack / Stroke	Y	N	Psychiatric Problems
Y	N	Blood Transfusion	Y	N	Heart Murmur	Y	N	Rheumatic / Scarlet Fever
Y	N	Cancer / Chemotherapy	Y	N	Heart Surgery / Pacemaker	Y	N	Severe / Frequent Headaches
Y	N	Congenital Heart Defect	Y	N	Hemophilia / Abnormal Bleeding	Y	N	Shingles
Y	N	Diabetes / Tuberculosis (TB)	Y	N	Hepatitis	Y	N	Sinus Problems
Y	N	Difficulty Breathing	Y	N	High / Low Blood Pressure	Y	N	Ulcers / Colitis
Y	N	Drug / Alcohol Abuse	Y	N	HIV+ / AIDS	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had ______

______

Are you allergic to any of the following? Y N Aspirin Y N Codeine Y N Dental Anesthetics Y N Erythromycin
Y N Penicillin Y N Tetracycline Y N Other ______

I understand that the information that I have given to you is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
I am aware that I am responsible for all charges incurred, regardless of my dental coverage.
I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

______
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.
Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally have reviewed the dental information above with the patient named herein. Initials: ______ Date: ______

Doctor's Comments: ______

______

MEDICAL HISTORY UPDATE

I have read my medical history dated ________ and confirmed that it states past and present medical conditions. ______
Initials Date

I have read my medical history dated ________ and confirmed that it states past and present medical conditions. ______
Initials Date

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Initials Date

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Initials Date

MEDICAL HISTORY FORM

Please fill out this form completely. The better we communicate, the better we can care for you.

GORDON ENGSTRAND FAMILY DENTISTRY, LLC
Ridgehill Professional Building, Suite 357
2000 Plymouth Road
Minnetonka, MN 55305
Phone (952) 544-1449

ABOUT YOU

Today's Date _____ **Name:** _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female Birthdate: _____ /_____ /_____ Age: _____

Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Are you a full-time student? _____ If so, where? _____

Home Address: _____
Apt/Condo #

_____
City State Zip

Home #: _____ Cell / Other #: _____

Employer: _____ How long there? _____

Employer's Address: _____ Occupation: _____

Work #: _____ Email: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us? _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

EMERGENCY CONTACT INFORMATION

In the event of an emergency, who should we contact?

His / Her Name: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Work #: _____ Ext: _____ DL #: _____

Social Security #: _____ Birthdate: _____ /_____ /_____

DENTAL INSURANCE

Primary Dental Insurance Insurance Co. Name: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____ Insured's Name: _____

Relationship: _____ Insured's Birthdate: _____ /_____ /_____ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance Insurance Co. Name: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____ Insured's Name: _____

Relationship: _____ Insured's Birthdate: _____ /_____ /_____ Insured's SS #: _____

Insured's Employer: _____