McNiel Family Dentistry, PC.
1905 Abbot Rd.
East Lansing, MI 48823

(517)351-6140
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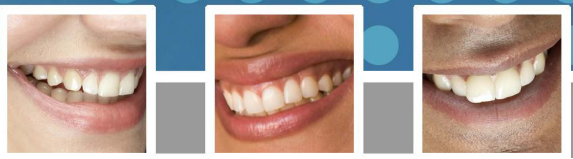

BEFORE FILLING OUT: *Computer Users: Download PDF & open in Acrobat *Mobile Users: 1. Download Adobe Acrobat Reader app
2. Import to Acrobat
3. Fill & Sign

Today's Date

Patient Information

Chart #. FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: SS #. Prev. Visit:

Email Address: Best time to call:

Phone: Home Work Ext Mobile Fax Other

Address:

City State Zip Code

Whom may we thank for referring you to our practice?

Insurance Company Internet Patient/Other (Name Below)

In addition to phone calls, I agree to be contacted via the following methods for appointment confirmation:

Text Email

I would like to receive newsletters or promotions:

Yes No

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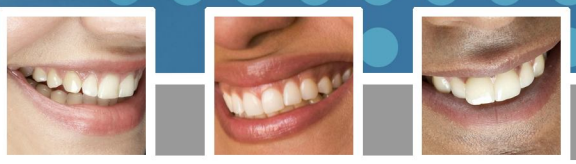

General Information

Impairments or Conditions We Should Be Aware of Prior to Treatment

☐ Hearing ☐ Learning ☐ Mobility ☐ Vision

☐ Autism ☐ ADD or ADHD ☐ Behavior Issues

Dental History

Have you ever been told to take antibiotics prior to dental treatment?

☐ Yes ☐ No

If yes, please provide the name and phone number of physician who recommended premedication. Please also include the reason you have been asked to premedicate. ie joint replacement, heart valve replacement etc.

Are you currently experiencing dental pain or discomfort?

☐ Yes ☐ No

What is the reason for your visit today?

☐ Routine Examination and Cleaning ☐ Other

If "Other" Please explain

Date of your last dental appointment:

What was done at that time?

☐ Examination and/or Cleaning ☐ Other

If "Other", what was done at that time?

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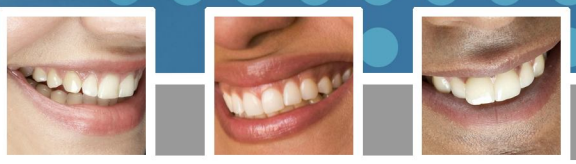

Former Dentists Name (if availble)

Former Dentists Phone Number (If available)

Have you had any problems associated with previous dental treatment?

☐ Yes ☐ No ☐ Unknown

If "Yes", please explain.

Check those that apply:

- ☐ Food or floss catches between your teeth.
- ☐ Gums bleed when brushing or flossing.
- ☐ History of orthodontics (braces).
- ☐ History of periodontal (gum) problems.
- ☐ Mouth is dry.
- ☐ Sores or ulcers in your mouth.
- ☐ Teeth are sensitive to cold, hot, sweets or pressure.
- ☐ Wear dentures or partials.
- ☐ Brux or grind teeth.
- ☐ Clicking, popping or discomfort in the jaw.
- ☐ Earaches or neck pain.
- ☐ History of serious injury to head or mouth.
- ☐ Participate in active recreational activities.

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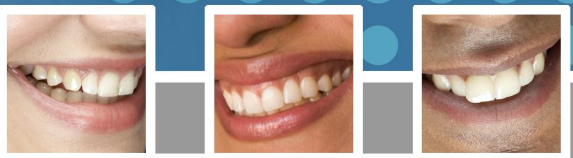

Is your home water supply fluoridated?

☐ Yes ☐ No ☐ Unknown

Do you drink bottled or filtered water?

☐ Yes ☐ No ☐ Unknown

If yes, how often?

☐ Daily ☐ Weekly ☐ Occasionally

Are you happy with your smile?

☐ Yes ☐ No

If "No". What would you like to change about your smile?

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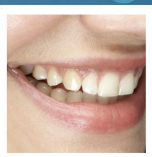
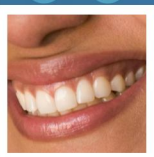
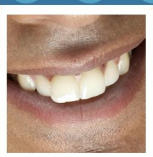

Medical History

Are you now under the care of a physician?

☐ Yes ☐ No

What are you being treated for?

☐ General Health ☐ Other

If "Other", what condition is being treated?

Physician's Name

Physician's Phone Number with Area Code

Are you in good health?

☐ Yes ☐ No ☐ Unknown

Date of Last physical exam.

Have you had a serious illness, operation or been hospitalized in the past 5 years?

☐ Yes ☐ No ☐ Unknown

If "Yes", what was the illness or problem?

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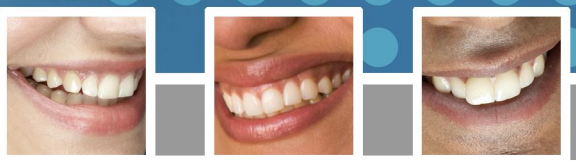

Heart Disease/Problems: Please call our office prior to your appointment if any of the following are checked.

Check if you have or have a history of any of the following:

- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Artificial Heart Valves
- ☐ Cardiovascular Disease
- ☐ Congenital Heart Defect
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Damaged Heart Valves
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease

Name and phone number (including area code) of physician currently monitoring heart related Issue.

Joint Replacement:

Have you had an othopaedic total joint (hip, knee, elbow, finger) replacement?

- ☐ Yes (Please call our office prior to your appointment.)
- ☐ No

If "yes", Date?

If "Yes", did you have any complications?

- ☐ Yes
- ☐ No
- ☐ Unknown

Surgeon's Name and Phone Number with Area Code

Involved Joint

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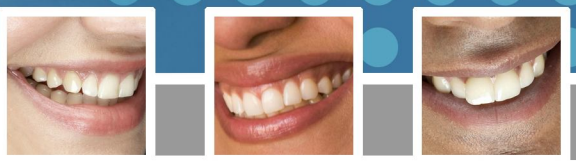

EMERGENCY CONTACT:

Phone number:

Women Only:

Are you pregnant?

☐ Yes ☐ No ☐ Unknown

If "Yes" Please contact our office prior to your scheduled appointment.

If "Yes", number of weeks.

Name and number (including area code) of physician/obstetrician monitoring your pregnancy.

Are you taking birth control pills or hormonal replacement?

☐ Yes ☐ No

Are you nursing?

☐ Yes ☐ No

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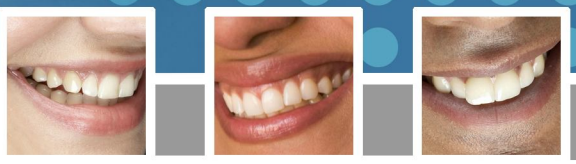

Please mark to indicate if you have or have a history of having any of the following diseases or problems.

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Abnormal Bleeding
- [ ] AIDS/HIV
- [ ] Allergy Amoxicillin
- [ ] Allergy Antihistamin
- [ ] Allergy Aspirin
- [ ] Allergy Codeine
- [ ] Allergy Erythromycin
- [ ] Allergy Iodine
- [ ] Allergy Keflex
- [ ] Allergy Latex
- [ ] Allergy Other
- [ ] Allergy Penicillin
- [ ] Allergy Peridex
- [ ] Allergy Sulfa
- [ ] Anemia
- [ ] Angina
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Autoimmune Disorder
- [ ] Blood Pressure High
- [ ] Blood Pressure Low
- [ ] Blood Transfusion
- [ ] Bronchitis
- [ ] Cancer
- [ ] Chemo Therapy
- [ ] Chronic Pain
- [ ] Dental Anxiety/Fear
- [ ] Diabetes I or II
- [ ] Eating Disorder
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive Urination
- [ ] Fainting/Seizures
- [ ] GE Reflux/Heartburn
- [ ] GI Disorder
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Hemophilia
- [ ] Hepatitis/Liver
- [ ] Kidney Problems
- [ ] Mental Health Issue
- [ ] Neurological Issue
- [ ] NOTES
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Radiation Treatment
- [ ] Respiratory Disorder
- [ ] Rheumatoid Arthritis
- [ ] Severe Headaches
- [ ] Severe Weight Loss
- [ ] Sexually Transmitted
- [ ] Sinus Trouble
- [ ] Sleep Disorder
- [ ] Stroke
- [ ] Swollen Glands Neck
- [ ] Systemic Lupus
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Ulcers

Do you wear contact lenses?

- [ ] Yes
- [ ] No

Allergies - Please detail allergies not listed above.
Diseases/Problems - Please provide details regarding diseases/problems checked above.

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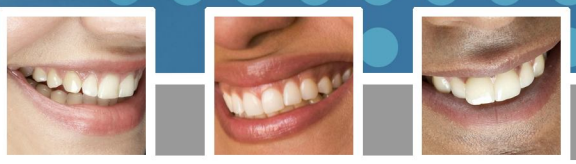

Please detail any other medical issues we should be aware of:

Are you taking or have you recently taken any prescription or over the counter medicine(s)?

☐ Yes ☐ No

If "Yes", please list all, including prescription medications, vitamins, natural or herbal preparations and/or diet supplements.

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) of phen-fen (fenfluramine-phentermine combinantion)?

☐ Yes ☐ No ☐ Unknown

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease?

☐ Yes ☐ No ☐ Unknown

Since 2001, were you treated or are your presently scheduled to begin treatment with the intravenous bisphophonates (Areia or Zometa) for bone pain, hypercalcemia or skeletal complications resluting form Paget's disease, mulitiple muyeloma or matastatic cancer?

☐ Yes ☐ No ☐ Unknown

If "Yes", date treatment began.

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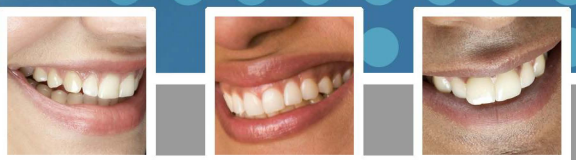

Do you drink alcoholic beverages?

☐ Yes ☐ No

If "Yes", how much do you typically drink in a week?

If "Yes", how much alcohol did you drink in the last 24 hours?

Do you use controlled substances (drugs)

☐ Yes ☐ No ☐ Unknown

Do you smoke medical or recreational marijuana?

☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)?

☐ Yes ☐ No

If "Yes", are you interested in stopping?

☐ Yes ☐ No ☐ Unknown

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will relay on this information for treating me. I acknowledge that my questions, if any about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/.her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature: _____ Date:

Relation to Patient if Not Self

Click SUBMIT button to send your completed form to our office (only works in Adobe Acrobat).

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SUBMIT

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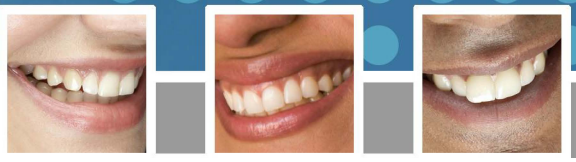

Response Date:

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