



DR. STEPHANIE GRUENES
Center for Cosmetic Dentistry

YOUR PERFECT SMILE STARTS HERE

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13734 First Street / PO Box 38 / Becker, MN 55308

MEDICAL AND DENTAL HISTORY:

Patient Name:
Last First MI Preferred Name

Physician/Clinic Name:

Are you currently under medical care?
 Yes No

Within the last 5 years, have you been hospitalized for any surgical operation or illness? Please explain:

Have you ever had excessive bleeding requiring special treatment?

Please list all current medications (prescription and non-prescription):

WOMEN ONLY:

Are you pregnant or do you think you may be pregnant?
 Yes No

Are you nursing?
 Yes No

Are you taking birth control pills?
 Yes No

MEDICAL ALERTS:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Aids/HIV Infection | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Premed |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Allergy - Any Metals | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergy Codeine | <input type="checkbox"/> Chemo/Radiation | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy Iodine | <input type="checkbox"/> Cong. Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> See Pt Note |
| <input type="checkbox"/> Allergy Latex | <input type="checkbox"/> Cong. Heart Problem | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Allergy Novocaine | <input type="checkbox"/> Controlled Substance | <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> STD |
| <input type="checkbox"/> Allergy Pen/Antib. | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergy Sulfa | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Art. Heart Value | <input type="checkbox"/> Fainting/Dizzy Spell | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastric Ulcers | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral V. Prolapse | <input type="checkbox"/> Other concerns: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> No Epinephrina | _____ |

DENTAL HISTORY:

Previous Dentist:

Last dental visit: Last x-rays taken: How often do you brush? How often do you floss?

Do your gums bleed with brushing or flossing?

Yes No

Do you have sensitive teeth? (Hot, Cold, Sweets)

Yes No

Do you frequently get cold sores?

Yes No

Do you frequently get food caught between your teeth?

Yes No

Do you clench or grind teeth?

Yes No

Do you wear a guard to protect your teeth at night?

Yes No

Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

Yes No

Do you have any dental problems at this time?

Yes No

Do you have any lumps or sores in or near your mouth?

Yes No

Have you had any head, neck or jaw injuries?

Yes No

Have you ever had a bad experience in a dental office?

Yes No

Have you ever experienced any of the following problems in your jaw?

Clicking Difficulty chewing Difficulty opening or closing Pain

AUTHORIZATION AND RELEASE:

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or guardian: _____ Date:

Relationship to patient: Response Date: