Dr. Harold K. Heuszel & Associates, DDS, FAGD

Today's Date: _____

About You:

Mr. Miss Ms. Mrs. _____ _____ _____
(circle one) Last Name First Name MI

Preferred Name: _____ DOB: ____ / ____ / _____ Age: _____

SSN: _____ - _____ - _____ Driver's License #: _____

Home Phone: _____ Work/Other Phone: _____

E-Mail Address: _____

Home Address:

_____ _____ _____ _____
Street City State Zip

Other Family Members Seen by Dr. Heuszel: _____

Who may we thank for referring you? _____ _____
Name Relationship

When and where is the best time to reach you? _____

About Your Employer: ☐ I'm unemployed ☐ I'm retired ☐ I'm a full-time student

Employer Name: _____ Occupation: _____

Employer Address:

_____ _____ _____ _____
Street City State Zip

About Your Spouse: ☐ I'm Not Married

Name: _____ DOB: ____ / ____ / _____ SSN: _____ - _____ - _____

Phone: _____ Driver's License #_____ Employer: _____

Dental Information:

Previous/Present Dentist Name: _____ Last Visit: _____

Street: _____ Phone: _____

Responsible Party Info: ☐ **I am the responsible party.**

Name: _____ Employer: _____

SSN: _____ - _____ - _____ Driver's License #: _____

Home Phone: _____ Work/Other Phone: _____

E-Mail Address: _____

Billing Address:

_____ _____ _____ _____

Street City State Zip

Primary Dental Insurance:

Insurance Name: _____ Insurance Company Phone #: _____

Insurance Address: _____

Group/Policy #:_____ Insured's Name: _____

Relationship to Patient: _____ Insured's DOB: ____ / ____ / _____

Insured's Employer: _____ SSN: _____ - _____ - _____

Orthodontic Coverage: ☐ Yes ☐ No

Secondary Dental Insurance:

Insurance Name: _____ Insurance Company Phone #: _____

Insurance Address: _____

Group/Policy #:_____ Insured's Name: _____

Relationship to Patient: _____ Insured's DOB: ____ / ____ / _____

Insured's Employer: _____ SSN: _____ - _____ - _____

Orthodontic Coverage: ☐ Yes ☐ No

Emergency Contact:

Name: _____ Relation: _____

Phone: _____ Ext. _____

2nd Phone: _____ Ext. _____

Dental History:

Why have you come to the dentist today? _____

Are you currently in pain? ☐Yes ☐No Your current dental health is: ☐Good ☐Fair ☐Poor

Have you ever had a serious/difficult problem associated with previous dental work? ☐Yes ☐No

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐Yes ☐No

Do you like your smile? ☐Yes ☐No Do your gums ever bleed? ☐Yes ☐No

How many times a *day* do you brush? _____ How many times a *week* do you floss? _____

Type of bristles? (circle one): Soft Medium Hard

Medical History:

Do you have a personal physician? ☐Yes ☐No Last Visit: _____

Name: _____ Phone:_____

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you currently under the care of a doctor? ☐Yes ☐No

If yes, please explain: _____

Are you taking any prescription drugs? ☐Yes ☐No List: _____

For Women Only:

Are you taking birth control pills? ☐Yes ☐No Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?:

☐Yes ☐No Aspirin ☐Yes ☐No Erythromycin

☐Yes ☐No Codeine ☐Yes ☐No Dental Anesthetics

☐Yes ☐No Latex ☐Yes ☐No Tetracycline

☐Yes ☐No Penicillin Other: _____

Have you ever had any of the following diseases or medical problems?:

☐Yes	☐No	Prothesis	☐Yes	☐No	History of Scarlet Fever
☐Yes	☐No	Heart attack	☐Yes	☐No	Congenital Heart Def.
☐Yes	☐No	Cancer	☐Yes	☐No	Abnormal bleeding
☐Yes	☐No	Diabetes	☐Yes	☐No	Artificial Valves
☐Yes	☐No	Rheum. Fev.	☐Yes	☐No	Heart surgery/Pacmkr.
☐Yes	☐No	HIV+/AIDS	☐Yes	☐No	Any stays in the hospital
☐Yes	☐No	Hemophilia	☐Yes	☐No	Kidney/Liver Problems
☐Yes	☐No	Asthma	☐Yes	☐No	Mitral Valve Prolapse
☐Yes	☐No	Hepatitis	☐Yes	☐No	Artificial bones/joints
☐Yes	☐No	Tuberculosis	☐Yes	☐No	Sev./Freq. headahces
☐Yes	☐No	Shingles	☐Yes	☐No	Hi/Lo blood pressure
☐Yes	☐No	Fever blister	☐Yes	☐No	Drug/Alcohol abuse
☐Yes	☐No	Venereal dis.	☐Yes	☐No	Anemia/Radiation treatment
☐Yes	☐No	Ulcers/Colitis	☐Yes	☐No	Blood transfusion
☐Yes	☐No	Heart Murm.	☐Yes	☐No	Glaucoma
☐Yes	☐No	Emphysema	☐Yes	☐No	Difficulty breathing
☐Yes	☐No	Sinus Problems	☐Yes	☐No	Convulsions/Epilepsy
☐Yes	☐No	Other: _____			

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

_____

Signature Date

OFFICE USE ONLY – OFFICE USE ONLY – OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.
Initials: _____ Date: _____

Medical History Update:
Date: _____ Sig: _____
Comments: _____