MILWAUKEE HEALTH SERVICES, INC.

MHSI DENTAL DEPARTMENT

Patient Information

Name______________________________ (Last / First / Middle) Date of Birth____/____/_______ Sex: ❑ Male ❑ Female

Maiden Name______________________________ Social Security Number______________________

Address______________________________ City________________ State_____ Zip__________

Home Phone______________________________ Cell Phone______________________________

Emergency Contact Person and Phone Number______________________________

Dental History

Have you ever seen a dentist? ❑ Yes ❑ No If so, when?______________________________

How often do you brush your teeth?__________________ How often do you floss your teeth?__________________

Do you have dental pain or discomfort? ❑ Yes ❑ No if so, where? ______________________________

Medical History

Physician______________________ Office Phone__________________ Date of last visit________________

Are you under medical treatment now? ❑ Yes ❑ No

Have you been hospitalized for any surgery or serious illness in the last 5 years? ❑ Yes ❑ No

If yes, please explain: ______________________________

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

Have you ever taken Phen-Fen/Redux? ❑ Yes ❑ No

Are you taking or have you had bisphosphonates (bone hardening medication)? ❑ Yes ❑ No

Are you taking blood thinning medication? ❑ Yes ❑ No

Are you taking any medications including nonprescription medication? (list all of them) ❑ Yes ❑ No

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Are you allergic to any of the following?

Local anesthetics	❑ Yes ❑ No	Any metals (nickel, mercury, etc)	❑ Yes ❑ No
Penicillin or other antibiotics	❑ Yes ❑ No	Latex rubber	❑ Yes ❑ No
Aspirin	❑ Yes ❑ No	Sulfa Drugs	❑ Yes ❑ No
Codeine or other narcotics	❑ Yes ❑ No	Other ____________________	❑ Yes ❑ No

Check if you have or have had any of the following:

❑ ADD/ADHD	❑ Chemotherapy	❑ Heart Attack	❑ Radiation Therapy
❑ AIDS or HIV infection	❑ Chest Pains	❑ Heart Disease	❑ Respiratory Problems
❑ Alcohol/Drug Addiction	❑ Congestive Heart Failure	❑ Heart Murmur	❑ Rheumatic Fever
❑ Anemia	❑ Depression	❑ Hemophilia	❑ Sexually Transmitted Disease
❑ Arthritis	❑ Diabetes	❑ Hepatitis	❑ Stomach Trouble/Ulcers
❑ Asthma	❑ Easily Winded	❑ High Blood Pressure	❑ Stroke
❑ Artificial Heart Valve	❑ Emphysema	❑ Joint Replacement	❑ Swollen Ankles
❑ Bipolar Disorder	❑ Epilepsy/Seizures	❑ Kidney Diseases	❑ Thyroid Problem
❑ Blood Disorder	❑ Fainting	❑ Liver Disease	❑ Tuberculosis
❑ Cancer	❑ Glaucoma	❑ Low Blood Pressure	❑ Mental disorder
❑ Cardiac Pacemaker	❑ Hay Fever/Allergies	❑ Mitral Valve Prolapse	❑ OTHER________________

Are you pregnant or think you may be pregnant? ❑ Yes ❑ No If yes, due date____________________

Are you nursing? ❑ Yes ❑ No

Are you taking oral contraceptives? ❑ Yes ❑ No

I certify that I have read the above questions and I have accurately answered all of them. I understand that providing incorrect information can be dangerous to my health, 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 of Patient/Legal Guardian______________________________ Date________________

Dentist's Signature______________________________ Date________________