MEDGAUS
DENTAL CARE

2550 MOSSIDE BLVD., #317 MONROEVILLE, PA 15146
412-373-0310 FAX: 412-373-1779
www.MedgausDentalCare.com

PATIENT REGISTRATION AND HEALTH HISTORY

IF THIS APPOINTMENT IS FOR YOU START HERE →

DATE			1
NAME			
SPOUSE			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDAY	AGE		

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE →

DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDAY	AGE	GRADE	
SCHOOL			
IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO			

SOCIAL SECURITY # - -

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
EMPLOYEE	
UNION OR LOCAL NO.	
GROUP NO.	
EMP. BADGE NO.	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
EMPLOYEE	
UNION OR LOCAL NO.	
GROUP NO.	
EMP. BADGE NO.	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	

GETTING TO KNOW YOU	3
IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE? THEIR NAME:	
REFERRED TO US BY	
HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE ONE) BROCHURE WELCOME LETTER NEWSLETTER WEBSITE FRIEND OR RELATIVE: _____	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY / STATE / ZIP	
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY / STATE / ZIP	

YOUR:	
EMAIL:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.
YOUR SPOUSE:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.

TIME 8:32 AM

Dr. Carl Medgaus D.M.D.

DATE 12/3/2003

MEDICAL HISTORY

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No ◯ N/A _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ◯ N/A _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ◯ N/A

Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Are you on a special diet? ◯ Yes ◯ No ◯ N/A

Do you use controlled substances? ◯ Yes ◯ No ◯ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A _____

Comments: _____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

MEDGAUS
DENTAL CARE

CARL MEDGAUS, DMD

Patient:_____ Date:_____

Chief Complaint:

What are your dental complaints in order of importance to you?

_____

_____

_____

How is your Dental condition affecting you daily?

_____

_____

Expectation:

If we were completing treatment today, tell me all of the things you need that treatment to do for you to be thrilled that you did it?

_____

_____

_____

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