Roth Dental Care

Gary D Roth DDS & Alex J Roth DDS
205 N B Street Fairfield, Iowa
(641)-472-3044

WELCOME

Thank you for choosing our dental health care team! Please provide us with a thorough history of past and current medical treatments; to include all medications (prescription and over the counter), all known drug allergies/adverse reactions, recent and past surgeries and hospitalizations.

While it may not seem of any consequence, many medical conditions and medications can have a significant impact on dental treatment and diagnosis. In order for us to best serve you in the safest environment possible please be as complete as you can and do not hesitate to ask us if any assistance is needed – we will be happy to help!

All information in this form is confidential and only for our records.

Thank You!
The Roth Dental Team

PATIENT INFORMATION

Patient Name_____ Preferred Name_____

Birth Date_____ Social Security Number(SSN)_____

If a Minor, parent or legal guardian's name_____ SSN_____

Home Phone_____ Work Phone_____ Cell Phone_____
Mailing Address_____ City_____ State_____ Zip_____

Occupation_____ Employer_____

If Married: Spouses Name_____ Employer_____

How did you hear about our office/who can we thank for referring you?_____

What is the primary reason you are seeking dental care today? _____

_____

EMERGENCY CONTACT: NAME_____ PHONE #_____

PATIENT MEDICAL HISTORY

1. Current Medical Treatment Facility_____
2. Current Physician or other Health Care Provider_____
3. Date of Last Exam/Physical_____
4. Are you currently under medical treatment now? Y N
   If yes please explain:_____
   _____
5. Have you been hospitalized within the last 5 years for any surgical operation or serious illness? Y N
   If yes please explain:_____
   _____
6. Are you currently taking any medications (i.e prescription, over the counter and/or herbals)? Y N
   Please list:_____
   _____
7. Have you ever taken Fosamax, Boniva, Actonel or other Bisphosphonates to treat cancer? Y N
   If yes, when were these were taken?_____
8. Do you currently use tobacco products? Y N Were you a past of user of tobacco? Y N
   If a smoker, how much for how long?_____
   If a user of smokeless tobacco how much for how long?_____
9. Do you have any clotting or bleeding disorders, or taking any anti-clotting medication to include Aspirin? Y N
   If yes please explain:_____
10. Do you have any artificial joints or heart valves? Y N
    If yes please explain and if possible include date of surgery:_____
11. Are you allergic or had any adverse reactions to any of the following?
    Local Anesthetics (i.e Novocain): Y N
    Latex Materials: Y N
    Antibiotics: Y N Which one(s)_____
    Codeine or other Narcotic Pain Medications: Y N
    NSAIDS (i.e Ibuprofen (Motrin), Tylenol, Aspirin): Y N
    Any metals (i.e nickel, tin, gold etc.)
    Please list any other allergies you may have:_____
    _____
12. Have you ever had or have any of the following? (Please 'X' or Circle condition)

High Blood Pressure	Heart Disease	Seasonal Allergies
Heart Attack	Heart Murmur	Tuberculosis
Stroke	Angina	Other lung/respiratory illness
Rheumatic Fever	Frequently Tired	Glaucoma
Seizure Disorder	Sleep Apnea	Other eye illness
Fainting Spells	Blood Disorder	History of Alcohol Abuse
Asthma	Emphysema	Cardiac Pacemaker
Low Blood Pressure	Cancer	Bronchitis/Chronic Cough
Leukemia	Arthritis	Mental Health Problems
Diabetes	Hepatitis/Jaundice	Radiation to the head or neck
Kidney Disease	STD's/STI's	Osteoporosis
AIDS/HIV Infection	Stomach Ulcers	Immune System Disorder
Thyroid Condition	Acid Reflux/GERD	OTHER:_____

13. For Women: Are You Pregnant or think it is a possibility you could be Pregnant? Y N Delivery Date_____
    Are You Nursing? Y N
    Are You Taking Oral Contraceptives? Y N

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location_____ Date of Last Visit_____

Do you experience anxiety or fear prior to and/or during dental treatment? Y N

Do you have a history of "bad" experiences at the dentist? Y N

Do you have a significant gag reflex or gag easily? Y N

Have you ever experienced any prolonged bleeding after dental treatment? Y N

Do you currently have any pain associated with any of your teeth? Y N

Do your gums bleed frequently when you brush and/or floss? Y N

Do you have any sores or lumps in your mouth that come and go or do not heal? Y N

Do you have a history of trauma or injuries to the face, jaws, teeth or head? Y N

Do you suffer from frequent Sinus issues/infections? Y N

Do you suffer from xerostomia (dry mouth)? Y N

Have you ever had orthodontic treatment (braces on your teeth)? Y N

Do you suffer from any of the following Temporomandibular Joint (TMJ) issues?
- Clicking or popping on one or both sides? Y N
- Pain in the joint/ear/face? Y N
- Limited or difficult opening/closing of the mouth? Y N
- Pain when chewing? Y N
- Is there a specific time of day the pain is at its worst? _____

Have you been told or know if you clench or grind your teeth at night or during the day? Y N

Do you have sensitive teeth? Y N
- If yes what triggers the sensitivity: _____

Do you like your smile? Y N
- If NO, what would you change about it?

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I also understand that any voluntary omissions of vital medical history cannot be the responsibility of the dental surgeon or any member of the Roth Dental staff and I certify that all questions above have been answered to the best of my ability.

_____ _____

Signature of patient/legal guardian Date MM/DD/YYYY