MCDC
MICHIGAN COMMUNITY DENTAL CLINICS, INC.

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact Person:_____ Relation to Patient:_____
Phone Number:_____

Health Information

Please Note: All of the following information is needed to allow us to treat you safely and will be kept CONFIDENTIAL.

Please check where you receive your medical care:

☐ Doctor's Office_____ Primary Care Provider:_____ ☐ Urgent Care/Emergency Room ☐ FQHC

PLEASE CHECK ALL THAT APPLY:

MEDICAL HISTORY

- ☐ ADD/ ADHD
- ☐ AIDS/HIV+
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Aortic Stenosis
- ☐ Arthritis/Osteoarthritis
- ☐ Asthma
- ☐ Auto-immune Disease
  - ☐ Rheumatoid
  - ☐ Fibromyalgia
  - ☐ Lupus
- ☐ Blood Disorder: _____
- ☐ Cancer:_____
  - ☐ Chemotherapy
  - ☐ Radiation
- ☐ Cataracts
- ☐ Cleft Palate
- ☐ Concussion / Head Injury
- ☐ COPD / Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Developmental Disabilities
- ☐ Diabetes
  - ☐ Stasis Ulcers
  - ☐ Hypoglycemia
- ☐ Eating Disorders
  - ☐ Anorexia
  - ☐ Bulimia
- ☐ Epilepsy / Seizures
- ☐ Gastro-intestinal Disorders
  - ☐ Heartburn / Indigestion
  - ☐ Ulcers
- ☐ Heart Disease
  - ☐ Heart Attack:_____
  - ☐ Heart Failure
- ☐ Hepatitis / Liver Disease
- ☐ High Blood Pressure / HTN
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis / Arthritis
- ☐ Postural Hypotension
- ☐ Pregnancy –Due Date:_____
- ☐ Psychiatric Disorders
- ☐ Sleep Disorders
  - ☐ CPAP
- ☐ Stroke / CVA: _____
  - ☐ Paralysis L- R
  - ☐ Weakness L- R
  - ☐ Aphasia
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Venereal Disease / STD

COMMON SYMPTOMS

- ☐ Abnormal Heart Beat / Arrhythmia
- ☐ Angina / Chest Pain
- ☐ Anxiety
- ☐ Bruise Easily
- ☐ Chronic Back Pain
- ☐ Chronic Hoarseness / Cough
- ☐ Constipation
- ☐ Difficulty Swallowing/ Dry Mouth
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness / Memory Loss
- ☐ Hives / Eczema
- ☐ Increased Thirst
- ☐ Migraines / Headaches
- ☐ Nausea / Vomiting
- ☐ Neuritis / Neuralgia / Sciatica
- ☐ Recent-Dramatic Weight Loss
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Swelling of Hands /Feet

SURGICAL HISTORY

- ☐ Artificial Joints:_____
- ☐ Heart Surgery: _____
  - ☐ Artificial Valve
  - ☐ Heart Murmur
  - ☐ Coronary Artery Bypass
- ☐ Implantable Cardiac Defibrillator
- ☐ Pacemaker
- ☐ Other Surgery:_____

Please place other health related issues you may be experiencing here:

_____

_____

_____

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MEDICATION SPECIFIC QUESTIONS

- Have you ever taken any of the following medications for Osteoporosis, Bone Cancer or Osteoarthritis?
  - ☐ Alendronate (Fosamax) Pamidronate (Aredia)
  - ☐ Alendronate & Cholecalciferal (Fosamax Plus)
  - ☐ Clondronate (Bonefes, Clasteon)
  - ☐ Etidronate & Calcium (Calcium Carbonate, Didrocal)
  - ☐ Etidronate Disodium (Didronel)
  - ☐ Ibandronate (Boniva)
  - ☐ Pamidronate (Aredia)
  - ☐ Risedronate (Actonel)
  - ☐ Ridedronate & Calcium (Actonel & Calcium)
  - ☐ Tiludronate (Skelid)
  - ☐ Xgeva (Denosumab)
  - ☐ Zoledronic Acid (Reclast, Zometa)
  - ☐ Any Other Bisphosphonate Medication:_____

- Have you ever taken the prescription drugs Flenfluramine, Flenfluramine with Phentermine (fen-phen), dexfenfluramine (Redux or Pondimin) or other weight loss products? ☐ No ☐ Yes If so, When:_____ Did you have a follow up Echocardiogram: ☐ No ☐ Yes

- Are you or have you ever taken a Blood Thinning Medication such as Coumadin/Warfarin, Pradaxa, Plavix, Aspirin or Other? ☐ No ☐ Yes

- Have You Been on Steroid Therapy in the Last 6 Months? ☐ No ☐ Yes If so, when:_____ Name of Drug: _____

PLEASE LIST ALL CURRENT MEDICATIONS (DOSAGE AND TIME YOU TAKE THEM)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ALL KNOWN ALLERGIES

☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Codeine ☐ Morphine ☐ Erythromycin ☐ Latex

Other Drug Allergies:_____

PERSONAL HEALTH HABITS

- Do you use tobacco products? ☐ No ☐ Yes Have you tried to quit? ☐ No ☐ Yes Do you want to know about quitting? ☐ No ☐ Yes

  ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Snuff If so, How long have you used? _____ How much do you use each day?_____

- Do you drink alcohol? ☐ No ☐ Yes ☐ Beer ☐ Liquor ☐ Wine ☐ Other
  How long have you drank alcohol? _____ How often do you drink alcohol? _____ Do you think you drink too much? ☐ No ☐ Yes

- Do you drink any of the following beverages? ☐ No ☐ Yes ☐ Coffee ☐ Pop (Diet/Reg) ☐ Tea If so, How often? _____

- Do you use recreational/street drugs? ☐ No ☐ Yes If so, what:_____ How often: _____ How long:_____

  When Did You Last Use?_____ **(It is very important that you are honest about this because it can affect your treatment.)**

IMPORTANT ADDITIONAL INFORMATION

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes
  If yes, please explain: _____

- Are you now under the care of a physician? ☐ No ☐ Yes
  If yes, please explain:_____ Name of Physician: _____

- Do you have any health problems that need further clarification? ☐ No ☐ Yes
  If yes, please explain:_____

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_____ ___/___/_____ _____ ___/___/_____
PATIENT (PARENT/GUARDIAN) SIGNATURE DATE DDS SIGNATURE DATE

Adult Dental History

Purpose of your Visit: _____

Are you aware of a problem? _____

How long since your last dental visit? _____

- Do you clench or grind your teeth? ☐ No ☐ Yes
- Have your ever experienced any pain or soreness in the muscles of your face Or around your ear or jaw click or pop? ☐ No ☐ Yes
- Are any of your teeth sensitive? ☐ No ☐ Yes
- Do your gums bleed or hurt? ☐ No ☐ Yes
- Are you pleased with the appearance of your teeth? ☐ No ☐ Yes
- Have you ever had gum treatment or surgery? ☐ No ☐ Yes
- Have you had any orthodontic treatment? ☐ No ☐ Yes
- Do you have a dental prosthesis (partial or complete denture)? ☐ No ☐ Yes

  If YES when was it made? Month _____ Year _____
- Are you interested in getting replacements? ☐ No ☐ Yes
- Have you had an unpleasant dental experience or is there anything about dentistry that your strongly dislike? ☐ No ☐ Yes
- Have you ever had to be pre-medicated with antibiotics or sedatives before dental treatment? ☐ No ☐ Yes

Please sign below

Child/Teen Dental History

- Is this your child's first visit to the dentist? ☐ No ☐ Yes
- If not, how long since their last visit?_____
- How often does your child brush their teeth? _____
- Does your child suck his/her thumb or fingers? ☐ No ☐ Yes
- Have there been injuries to teeth from falls or blows that could cause chips? ☐ No ☐ Yes
- Has your child had any problem with dental treatment in the past? ☐ No ☐ Yes
- Do you or your child think there is anything wrong with his/her teeth? ☐ No ☐ Yes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

_____ ___/___/_____ _____ ___/___/_____
PATIENT (PARENT/GUARDIAN) SIGNATURE DATE DDS SIGNATURE DATE