# Welcome to Apple Valley Dental Care
## Michael Bakken D.D.S

**The Benefits of a happy healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.**
**Please fill out this form completely. The better we communicate the better we can care for you.**

Today's Date_____

### About Patient

**Name**_____ **Male**____ **Female**____
First MI Last

Birthdate_____/____/_____ Social Security _____ Single____Married_____Divorced_____Other_____

**Home Address**_____
Street City St. Zip

Home Ph.#(_____)_____Pager/Cell # _____

Wk #(_____)_____ Ext._____

Employer_____Occupation_____

Other family members in our office._____

Someone not living with you in the case of emergency (name and ph.#)_____
Whom may we thank for referring you to our office ? _____

### Child / Spouse Information

Mother / Spouse Name_____ Date of Birth_____

Employer_____ S.S. #_____

Father/Spouse Name_____ Date of Birth_____

Employer_____ S.S.#_____

## Please give front desk your insurance card for submitting your treatment today.

**I agree that the information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my health history / insurance or personal status. I authorize the administration of such diagnostic and therapeutic procedures as may be necessary for proper dental care and photographs for identification. We give our patients the highest standard of care, we do not let insurances dictate your needs. I assign the providing Doctor all insurance benefits. I understand that I am solely responsible for payment of services rendered. Any insurance deductibles and copayments are payable at the time of service.**
**I understand that co-pays collected are *estimates only* and *payable at the time of service*. I agree to pay any finance / interest charges accrued on any unpaid balances.**
**I agree to pay collection / legal fees for collections if balance is not paid in full. This is a legal document.**
**I have received, read and understand your *Notice of Privacy Practices.* (HIPPA)**

Patient/Parent Signature_____Date_____

# Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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 | If yes |
| Have you ever been hospitalized or had a major operation? | ○ Yes ○ No | If yes |
| Have you ever had a serious head or neck injury? | ○ Yes ○ No | If yes |
| Are you taking any medications, pills, or drugs? | ○ Yes ○ No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | ○ Yes ○ No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ○ Yes ○ No | If yes |
| Are you on a special diet? | ○ Yes ○ No | |
| Do you use tobacco? | ○ Yes ○ No | |

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 ☐ Sulfa Drugs ☐ Local Anesthetics

| | | |
|---|---|---|
| Other? | ☐ | If yes |
| Do you use controlled substances? | ○ Yes ○ No | If yes |

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ○ Yes ○ No | Cortisone Medicine | ○ Yes ○ No | Hemophilia | ○ Yes ○ No | Radiation Treatments | ○ Yes ○ No |
| Alzheimer's Disease | ○ Yes ○ No | Diabetes | ○ Yes ○ No | Hepatitis A | ○ Yes ○ No | Recent Weight Loss | ○ Yes ○ No |
| Anaphylaxis | ○ Yes ○ No | Drug Addiction | ○ Yes ○ No | Hepatitis B or C | ○ Yes ○ No | Renal Dialysis | ○ Yes ○ No |
| Anemia | ○ Yes ○ No | Easily Winded | ○ Yes ○ No | Herpes | ○ Yes ○ No | Rheumatic Fever | ○ Yes ○ No |
| Angina | ○ Yes ○ No | Emphysema | ○ Yes ○ No | High Blood Pressure | ○ Yes ○ No | Rheumatism | ○ Yes ○ No |
| Arthritis/Gout | ○ Yes ○ No | Epilepsy or Seizures | ○ Yes ○ No | High Cholesterol | ○ Yes ○ No | Scarlet Fever | ○ Yes ○ No |
| Artificial Heart Valve | ○ Yes ○ No | Excessive Bleeding | ○ Yes ○ No | Hives or Rash | ○ Yes ○ No | Shingles | ○ Yes ○ No |
| Artificial Joint | ○ Yes ○ No | Excessive Thirst | ○ Yes ○ No | Hypoglycemia | ○ Yes ○ No | Sickle Cell Disease | ○ Yes ○ No |
| Asthma | ○ Yes ○ No | Fainting Spells/Dizziness | ○ Yes ○ No | Irregular Heartbeat | ○ Yes ○ No | Sinus Trouble | ○ Yes ○ No |
| Blood Disease | ○ Yes ○ No | Frequent Cough | ○ Yes ○ No | Kidney Problems | ○ Yes ○ No | Spina Bifida | ○ Yes ○ No |
| Blood Transfusion | ○ Yes ○ No | Frequent Diarrhea | ○ Yes ○ No | Leukemia | ○ Yes ○ No | Stomach/Intestinal Disease | ○ Yes ○ No |
| Breathing Problems | ○ Yes ○ No | Frequent Headaches | ○ Yes ○ No | Liver Disease | ○ Yes ○ No | Stroke | ○ Yes ○ No |
| Bruise Easily | ○ Yes ○ No | Genital Herpes | ○ Yes ○ No | Low Blood Pressure | ○ Yes ○ No | Swelling of Limbs | ○ Yes ○ No |
| Cancer | ○ Yes ○ No | Glaucoma | ○ Yes ○ No | Lung Disease | ○ Yes ○ No | Thyroid Disease | ○ Yes ○ No |
| Chemotherapy | ○ Yes ○ No | Hay Fever | ○ Yes ○ No | Mitral Valve Prolapse | ○ Yes ○ No | Tonsillitis | ○ Yes ○ No |
| Chest Pains | ○ Yes ○ No | Heart Attack/Failure | ○ Yes ○ No | Osteoporosis | ○ Yes ○ No | Tuberculosis | ○ Yes ○ No |
| Cold Sores/Fever Blisters | ○ Yes ○ No | Heart Murmur | ○ Yes ○ No | Pain in Jaw Joints | ○ Yes ○ No | Tumors or Growths | ○ Yes ○ No |
| Congenital Heart Disorder | ○ Yes ○ No | Heart Pacemaker | ○ Yes ○ No | Parathyroid Disease | ○ Yes ○ No | Ulcers | ○ Yes ○ No |
| Convulsions | ○ Yes ○ No | Heart Trouble/Disease | ○ Yes ○ No | Psychiatric Care | ○ Yes ○ No | Venereal Disease | ○ Yes ○ No |
| | | | | | | Yellow Jaundice | ○ Yes ○ No |

| | | |
|---|---|---|
| Have you ever had any serious illness not listed | ○ Yes ○ No | If yes |

Comments:

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:

X Date:_____