



Styles, Cotton & Milbert

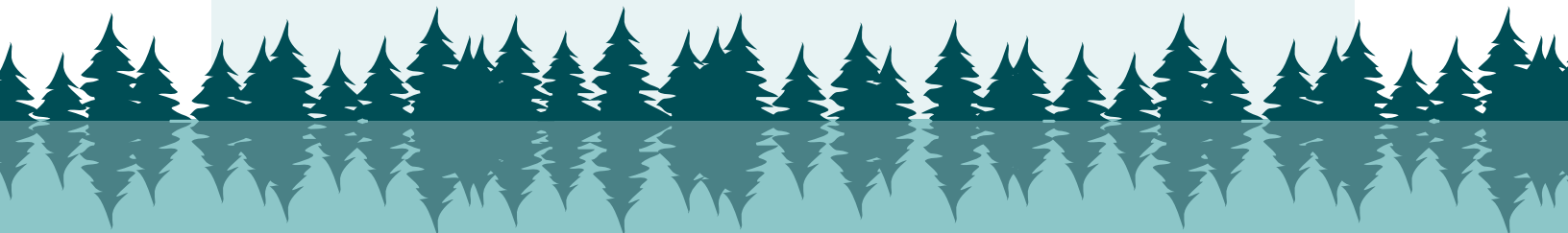
Patient Information & Health History

Patient:

Date:

Dr. Styles • Dr. Cotton • Dr. Milbert
stjoedds.com
(320) 363-7729

1514 E. Minnesota St.
St. Joseph MN 56374



Dental & Medical Health History

Note: Correct answers to the following questions will allow our doctors and their staff to treat you on a more individual basis, providing the care appropriate for your particular needs. It will allow Styles, Cotton & Milbert to treat you so there will not be an emergency. However, if an emergency situation does arise, this information will help insure proper treatment. Your answers are for our records only and will be considered confidential.

Date of Last Dental Visit: _____

How often do you brush your teeth? _____

My brush is... Soft Medium Hard

What other dental aids do you use?

Brush Dental Floss Fluoride Other

Check the statement that most applies to you...

1. My mouth is:

- Very Comfortable Moderately Comfortable
 Uncomfortable

2. I think the appearance of my mouth is excellent.

- I am satisfied with the appearance of my mouth.
 I am dissatisfied with the appearance of my mouth.

3. I will do anything to keep my natural teeth.

- I want to keep my teeth, but I have a certain budget of time and money that I am willing to spend on them.

4. I have set goals for my oral health with a previous dentist.

- I want to set goals concerning my dental health.

5. I have always done the best that was recommended for my dental health.

- I have not done what dentists have recommended to me.
 I rarely go, and don't care much about having any dental work completed.

6. I have put dentistry for myself and family high on my priority list.

- I have put dentistry for myself and my family low on my priority list.
 Dentistry is on my list but it's hard to find.

7. I think my present state of dental health is:

- Excellent Good Poor

What are some questions about dentistry and your oral health that you never had adequately answered?

Are you having discomfort at this time? Yes No

Does dental treatment make you nervous?

- No Slightly Moderately Extremely

What do you fear most about dental care?

These things are important to me about my dental health...

Have you ever had any serious trouble associated with previous dentistry? Yes No

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No

Place a mark on "yes" or "no" to indicated if you have ever had any of the following...

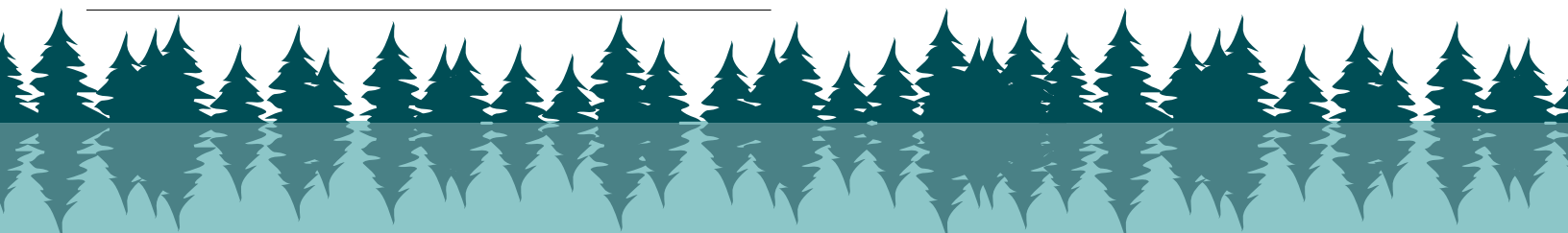
Mouth

- Bleeding, Sore Gums Yes No
Unpleasant Taste/Bad Breath Yes No
Burning Tongue/Lips Yes No
Frequent Blister, Lips/Mouth Yes No
Swelling/Lumps in Mouth Yes No
Orthodontic Treatments (Braces) Yes No
Biting Cheeks/Lips Yes No
Clicking/Popping Jaw Yes No
Difficulty Opening/Closing Jaw Yes No

Teeth

- Loose Teeth Yes No
Sensitivity to Cold Yes No
Sensitivity to Heat Yes No
Sensitivity to Sweets Yes No
Sensitivity to Biting Yes No
Food Impaction Yes No
Shifting in Bite Yes No
Change in Bite Yes No
Clenching/Grinding Yes No

If so, when: _____



Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name: _____

Last Visit to Physician: _____

Are you allergic or have you had a reaction to the following...

- | | | |
|-------------------------------------|------------------------------|-----------------------------|
| Local Anesthetic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Penicillin or Other Antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aspirin, Ibuprofen or Tylenol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Codeine, Valium® or Other Sedatives | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Latex or Metals | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? Yes No

If yes, please list: _____

Are you taking any medications, drugs or pills? Yes No

If yes, please list name and dosage: _____

Do you use tobacco? Chew Smoke

How often? _____ How long? _____

Check yes or no to indicate whether or not you have had or now have the following conditions or treatments:

- | | | | | | |
|----------------------------|--|---------------------------|--|--------------------------------|--|
| Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis/Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (T.B.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fen-Phen or Redox | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special or Restricted Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain (Angina) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies or Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Anxious | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone Disease or Bone Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Family History of Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

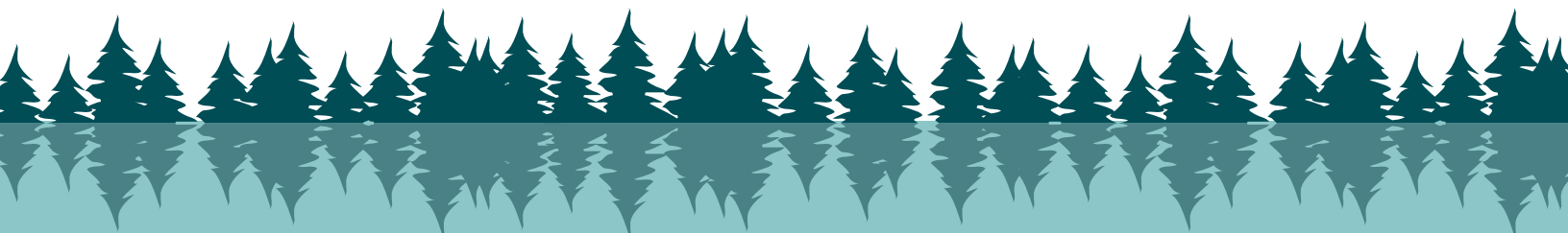
Any disease, condition or problem not listed: _____

Dr's comments: _____

Women

Are you pregnant or planning a pregnancy? Yes No Are you a nursing mother? Yes No

If yes, due date: _____



Patient Information

Patient

First: _____ Last: _____

Middle Initial: _____ Nickname: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work: _____ Cell: _____

Email: _____

Gender: Male Female

Age: _____ Birthdate: _____

Drivers License #: _____

Parent/Guardian: _____

Insurance

Subscriber's Name: _____

Relationship: _____ Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Dual Coverage: Yes No *If yes please complete the following*

Subscriber's Name: _____

Relationship: _____ Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Employment/School

Occupation: _____

Employer/School: _____

How long: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Spouse's name: _____

Employer: _____

How long: _____

Emergency Notification

Name: _____

Relationship: _____

Phone: _____

Who can we thank for the referral? _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

Signature of Patient or Guardian

Date

