Yvonne S. Hanley D.D.S.
Mark K. Murphy D.D.S.

Patient Information

Welcome to our office! Thank you for giving us the chance to serve you. Please fill in the following information to help us get to know you.

Name:_____

Today's Date:_____ Date of Birth: _____

Name you would like us to call you: _____

Address:_____

City: _____ State: _____ Zip:_____

Whom may we thank for referring you to our office?_____

Home Phone: _____ Work Phone:_____ Ext:_____

Other Phone: (optional) _____

Occupation: _____ Employer:_____

Social Security #: _____

Spouse's name: _____ Employer: _____

If child, parent's name: _____

Parent's address, if different: _____

_____

Person responsible for account: (if different from above) _____

Relationship to patient:_____

This office will respect the privacy of the information that you provide to us. We will only transmit the specific information necessary to consult with your physician, previous dentist, a dental specialist or laboratory to assist in your care, file an insurance claim on your behalf, correspond regarding an account or contact you to assist us in providing you care. The information I have provided is complete and accurate to the best of my knowledge.

Signature:_____

1409 College Way • Fergus Falls, MN 56537 • Phone 218-739-3245 • Fax 218-739-5626

Yvonne S. Hanley D.D.S.
Mark K. Murphy D.D.S.

Medical History

Name _____ Date of Birth _____

Personal Physician _____

Last Medical Exam _____

In case of emergency, who should we contact?

Name _____ Phone _____

Y	N	
☐	☐	Are you in good health?
☐	☐	Have you had any changes to your general health within the past year? If yes, what?

_____

Past hospitalizations/ surgeries/ radiation treatments:

_____

☐ ☐ Do you need to take antibiotics prior to dental treatment? If yes, why? _____

☐ ☐ Are you pregnant (women)?

Are you allergic or have you had adverse reaction to any of the following?

☐ ☐ Local Anesthetics
☐ ☐ Penicillin, Sulfa or other antibiotics
☐ ☐ Barbiturates, sedatives or sleeping pills
☐ ☐ Pain medications or narcotic analgesics
☐ ☐ Aspirin
☐ ☐ Latex

Are you taking any of the following medications?

☐ ☐ Antibiotics or sulfa drugs
☐ ☐ Anticoagulants (blood thinners), high blood pressure or heart medications
☐ ☐ Aspirin, cortisone (steroids) or anti-inflammatory medications
☐ ☐ Tranquilizers, antidepressants or pain medications
☐ ☐ Epilepsy or seizure medication
☐ ☐ Insulin or diabetic medication

Please list any additional medications you are currently taking:

_____

Do you have or have you ever had any of the following:

Y	N	
☐	☐	Heart Attack /Stroke
☐	☐	Heart Surgery – bypass, valve replacement or repair
☐	☐	Rheumatic Fever
☐	☐	Heart murmur
☐	☐	Mitral valve prolapse
☐	☐	Artificial valves
☐	☐	Congenital heart defect
☐	☐	Pain in chest on exertion
☐	☐	Shortness of breath after exercise
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Anemia
☐	☐	Bleeding problems
☐	☐	Prosthetic joint replacement
☐	☐	Rheumatoid arthritis
☐	☐	Osteoarthritis
☐	☐	Fibromyalgia
☐	☐	Autoimmune diseases
☐	☐	Kidney problems
☐	☐	Liver problems
☐	☐	Hepatitis
☐	☐	HIV/ AIDS
☐	☐	Diabetes / Hypoglycemia
☐	☐	Stomach problems
☐	☐	Ulcers
☐	☐	Respiratory problems
☐	☐	Emphysema
☐	☐	Difficulty breathing
☐	☐	Asthma/ Hayfever
☐	☐	Chronic Obstructive Pulmonary Disease
☐	☐	Tuberculosis
☐	☐	Communicable diseases
☐	☐	Sinus problems
☐	☐	Fainting/ Seizures/ Epilepsy
☐	☐	Severe/ Frequent headaches
☐	☐	Sleep disorder
☐	☐	Tobacco dependency
☐	☐	Alcohol or Drug dependency
☐	☐	Nervous disorder/ psychiatric treatment
☐	☐	Eating disorder

I understand the above information and have completed this form to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____

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OVER

Yvonne S. Hanley D.D.S.
Mark K. Murphy D.D.S.

Dental History

Please answer the following questions. Your responses will allow us to treat you on a more individual basis. Your answers are for our records only and are confidential.

What is your chief concern in seeking dental care? _____
Are you having any discomfort at this time? _____
How do you feel about your teeth and your smile? _____
_____
What would you change about your smile or teeth if you could? _____
_____
How long since your last visit to a dentist? _____
What was the purpose of your last dentist visit? _____
Who was your previous dentist? _____
When was your last preventative dental care (teeth cleaning)? _____
When did you last have a complete series of dental x-rays? _____
Have you ever had any trouble associated with previous dental treatment? _____
_____
_____
_____
Are you fearful of dental treatment? No_____ Slightly _____ Moderately _____ Extremely _____

Do you have or have you ever had:

Y	N	
☐	☐	Orthodontic treatment
☐	☐	Dental implants
☐	☐	Gingivitis or Periodontal disease
☐	☐	Bleeding, sore gums
☐	☐	Unpleasant taste or bad breath
☐	☐	Frequent blisters on lips or mouth
☐	☐	Swelling or lumps in mouth
☐	☐	Biting cheeks or lips
☐	☐	Clenching or grinding teeth
☐	☐	Clicking or popping noises in jaws
☐	☐	Soreness in jaw joint or jaw muscles
☐	☐	Difficulty opening or closing jaw
☐	☐	Missing or broken fillings
☐	☐	Loose teeth
☐	☐	Sensitivity to hot
☐	☐	Sensitivity to cold
☐	☐	Sensitivity to sweets
☐	☐	Sensitivity to biting
☐	☐	Change in bite

If you wear dentures, do you have trouble chewing or keeping them in place? _____
Do you have any particular questions you would like answered? (Sometimes it's easy to forget unless you write things down!) _____
_____
_____

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