FAMILY DENTISTRY™
DR. MICHAEL OTTO & DR. KRISTIN KOTECKI

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Mason City, Iowa 50401
641.424.6461

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Nora Springs, Iowa 50458
641.749.5430

ADULT PATIENT INFORMATION

Date _____

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 recieve. Thank you for answering the following questions.

PATIENT INFORMATION *Answers to all Questions are for Office Use and Strictly Confidential*

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ Zip Code _____

Sex: M F Birthdate ___/___/___ SS Number _____ Marital Status: S M W D

Email Address _____ Can We Contact You With This Address: Yes No

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Previous General Dentist (Name, Address & Phone Number) _____

How Did You Hear About Our Office ☐ Friends / Co-Worker ☐ Family ☐ Website / Internet ☐ Phone Book ☐ Location ☐ Other _____

Emergency Contact Name _____ Relation To You _____ Phone _____

SPOUSE'S INFORMATION

Name _____ Home Phone _____ Cell Phone _____

Sex: M F Birthdate ___/___/___ SS Number _____

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

INSURANCE INFORMATION

Primary Dental Insurance Company _____ Address _____

Insured's Name _____ Birthdate ___/___/___

Insurance ID Number _____ Subscriber _____ Group Number _____

Secondary Dental Insurance Company _____ Address _____

Insured's Name _____ Birthdate ___/___/___

Insurance ID Number _____ Subscriber _____ Group Number _____

MEDICAL HISTORY

1. Are You Under A Physicians Care Now?	Yes	No	If Yes, Explain _____
2. Have You Ever Been Hospitalized or Had A Major Operation?	Yes	No	If Yes, Explain _____
3. Have You Ever Had A Serious Head or Neck Injury?	Yes	No	If Yes, Explain _____
4. Are You Taking Any Medications, Drugs or Supplements?	Yes	No	If Yes, List _____
5. Do You Take, or Have You Taken, Phen-fen or Redux?	Yes	No	If Yes, Explain _____
6. Have You Ever Taken Any Medication Containing Bisphosphonates?	Yes	No	If Yes, List _____
7. Are You On A Special Diet?	Yes	No	If Yes, Explain _____
8. Do You Use Tobacco or Vape?	Yes	No	If Yes, Explain _____
9. Do You Use Controlled Substances?	Yes	No	If Yes, Explain _____

10. Are You Allergic To Any Of The Following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other If Other Please List: _____

MEDICAL HISTORY *(Continued From Previous Page)*

If You Are A Woman ☐ Are You Pregnant or Trying To Get Pregnant ☐ Are You Nursing ☐ Are You Taking Oral Contraceptives

MARK AN X IN THE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

☐ AIDS / HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis / Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores / Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells / Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack / Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble / Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain In Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Snoring / Sleep Apnea
☐ Spina Bifida
☐ Stomach / Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have You Ever Had A Serious Illness Not Listed? Yes No If Yes, List _____

Do You Currently Use A CPAP Machine? Yes No How Often _____

DENTAL HISTORY

1. Do You Have A Specific Dental Problem? Yes No If Yes, Explain _____
2. Do You Have Dental Examinations On A Routine Basis? Yes No How Often _____
3. Would You Describe Your Present Dental Health As Good? Yes No Comments _____
4. Do You Feel Nervous About Having Dental Treatment? Yes No If Yes, Explain _____
5. Have You Ever Had A Bad Experience In A Dental Office? Yes No If Yes, Explain _____
6. Do You Want To Keep Your Remaining Teeth? Yes No If No, Explain _____
7. Do You Like Your Smile? Yes No If No, Explain _____
8. Have You Had A Reaction To Dental Anesthetic? Yes No If Yes, Explain _____
9. Do You Need To Be Pre-Medicated For Dental Treatment? Yes No If Yes, Explain _____
10. Is There Anything You Would Like To Bring To Our Attention? Yes No If Yes, Explain _____
11. Do You Wish To Talk To The Doctor Privately? Yes No
12. How Often Do You Brush? _____ Floss? _____ Use Mouthwash? _____
13. What Has Been Used For Comfort In Previous Dental Treatment? ☐ Local Anesthetic ☐ N_2O Gas ☐ Neither

MARK AN X IN THE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

☐ Active Decay
☐ Bleeding Gums
☐ Gum Disease
☐ Orthodontic Treatment
☐ Tooth Straightening
☐ Root Canal Treatment
☐ Dental Implants
☐ Removable Dental Appliances
☐ Dentures
☐ Hot / Cold Tooth Sensitivity
☐ Sensitive To Sweets
☐ Sensitive When Chewing
☐ Bruxing or Grinding Teeth
☐ Clicking or Popping In Jaw
☐ Discomfort In Jaw Joint (TMJ)
☐ Food Wedging Between Teeth

Have You Ever Had Any Other Dental Procedures Not Listed? Yes No If Yes, Explain _____

Please List Any Questions, Comments or Additional Information Which May Assist Us In Providing For Your Care _____

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.

X _____ Date _____

Patient Signature (Parent or Guardian)