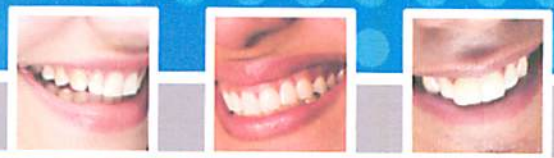
Melissa L. Hutchens, DDS, PA
538 South Main Street
Suite 130
Cambridge MN 55008
(763)552-1616
office@melissahutchensdds.com
www.melissahutchensdds.com



Dental History

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Date of Birth:

_____

Please take a moment to let us know about your medical and dental history. This information is confidential.

Former Dentist: Name, Address & Phone #

_____

Date of last dental visit and what was done?

_____

What is your daily homecare routine?

☐ daily brushing ☐ daily flossing ☐ electric toothbrush ☐ mouth rinse

Please mark any of the following to indicate yes in response to the question:

☐ Do your gums bleed when you brush or floss or have you been told you have gum disease?

☐ Do you currently have any dental implants, dentures, or partials?

☐ Do your teeth experience sensitivity to hot, cold, sweets or pressure?

☐ Is your mouth often dry?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Have you ever had complications following dental treatment?

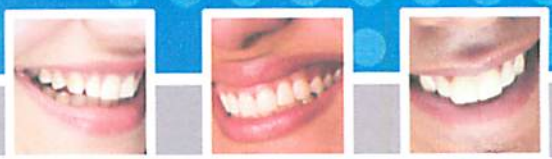
Anything else dental related you think we should know?

_____

If you could change anything about your teeth, mouth or smile what would it be?

_____

Melissa L. Hutchens, DDS, PA
538 South Main Street
Suite 130
Cambridge MN 55008
(763)552-1616
office@melissahutchensdds.com
www.melissahutchensdds.com



Medical History

Primary Care Physician's Name & Clinic:

Approximate date of your last medical exam?

Please mark any of the following to indicate yes in response to the question:

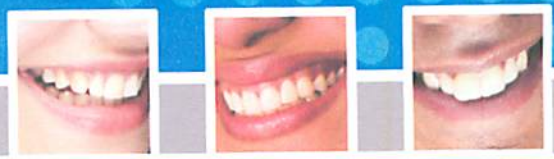
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Within the past year, have there been any changes in your general health?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked yes, please explain below:

Please list or supply list of any current medications? (include over-the-counter medications):

Do you have any known allergies?

Melissa L. Hutchens, DDS, PA
538 South Main Street
Suite 130
Cambridge MN 55008
(763)552-1616
office@melissahutchensdds.com
www.melissahutchensdds.com



Do you currently have or had in the past any of the following?

☐ *Pre-medication	☐ Allergy - Anesthetic	☐ Allergy - Codeine	☐ Allergy - Latex
☐ Allergy - Other	☐ Allergy - Penicillin	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Thinners	☐ Bone-building Drugs
☐ Cancer	☐ Chemical Dependency	☐ Chemotherapy	☐ Currently Pregnant
☐ Diabetes	☐ Diet Drug FenPhen	☐ Diet Drug Redux	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Heart Condition
☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ Jaundice
☐ Low Blood Pressure	☐ No Epinephrine	☐ Other	☐ Pacemaker
☐ Prosthetic Implant	☐ Psychiatric Care	☐ Radiation	☐ Sinus Trouble
☐ Stroke	☐ Thyroid problem	☐ Tuberculosis	☐ Ulcers

Do you have any other conditions,diseases, etc. not listed above that we should be aware of?

Authorization

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Signature or legal guardian_____

Response Date: