SANDERS DENTISTRY

Steven R. Sanders, D.D.S.
6314 Rucker Rd., Ste. B • Indianapolis, IN 46220
317-253-8004

Date _____

CONFIDENTIAL MEDICAL HISTORY

Patient's Name _____ Date of Birth _____

Age _____ M ____ F ____ Social Security # _____ Home Phone _____

Address _____ City _____ State _____ ZIP _____

Email Address _____

Employer _____ Work Phone _____ Cell Phone _____

Person Financially Responsible _____ Relation to Patient _____ Date of Birth _____

Spouse's Name _____ Employer _____

Work Phone _____ Social Security # _____

Children—Name and Ages: Former Dentist _____

1. _____ Last Visit _____

2. _____ Whom may we thank for referring you?

3. _____ _____

DENTAL INSURANCE

Primary Insurance

Subscriber's Name _____ Social Security Number _____ Date of Birth _____

Employer _____ Insurance Company Name _____

Insurance Company Address _____ Group # _____

Secondary Insurance

Subscriber's Name _____ Social Security Number _____ Date of Birth _____

Employer _____ Insurance Company Name _____

Insurance Company Address _____ Group # _____

Over please

Physician _____ Approximate date of last physical exam _____

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

	Yes	No		Yes	No
Heart Disease	☐	☐	High Blood Pressure	☐	☐
Rheumatic Fever	☐	☐	Ulcers	☐	☐
Tuberculosis	☐	☐	Diabetes	☐	☐
Glaucoma	☐	☐	Epilepsy-Convulsions	☐	☐
Heart Murmur	☐	☐	Anemia	☐	☐
Hepatitis	☐	☐	Tumors or Growths	☐	☐
Kidney Disease	☐	☐	Prolonged Bleeding	☐	☐
Chest Pains	☐	☐	Fainting Spells	☐	☐
Thyroid Trouble	☐	☐	AIDS-HIV Positive	☐	☐
Open Heart Surgery	☐	☐	Osteoporosis	☐	☐

	Yes	No
Are you now taking Bisphosphonates? *(marketed as Actonel, Avedia, Boniva, Didronel, Fosamax, Reclast, Skelid or Zometa)*	☐	☐
Are you now being treated by a physician or any health care professional?	☐	☐
If so, please explain:		
Are you allergic, or have you had an unusual reaction to any drug?	☐	☐
Have you ever had an adverse reaction to Novocain or Penicillin?	☐	☐
Are you now taking any drugs or medications? If so, what and how much?		
a: _____ b: _____ c: _____ d: _____ e: _____		
Have you ever experienced excessive or prolonged bleeding?	☐	☐
Have you ever experienced slow healing of a wound or incision?	☐	☐
Do you have an artificial limb or joint?	☐	☐
Do you have an artificial heart valve?	☐	☐
Do you have a pacemaker?	☐	☐
Are you pregnant? If so, what is your due date?	☐	☐
Do your gums bleed easily, feel tender or irritated?	☐	☐

Are your teeth sensitive to: Hot ☐ Cold ☐ Sweets ☐

Is there anything of importance in your medical history that the Doctor should know or be made aware of?

_____

Signature of Patient (Guardian) _____ Date _____

CONSENT FOR DENTAL TREATMENT

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or radiographs, as may be deemed necessary by the Doctor. Also, if I have any questions about any procedure, I may ask the Doctor or any staff member at any time.

Signature of Patient (Guardian) _____ Date _____