MICHAEL T. NYKAMP, D.D.S.

MEDICAL HISTORY

This medical history form has been prepared to provide you with the best care here in our office. Any information provided is strictly confidential.

Date: _____

Name: _____ Preferred Name: _____

D.O.B: _____ Sex: M ☐ F ☐ Social Security Number: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____

Check one:

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____ years

Employer/Occupation: _____

Whom may we thank for referring you? _____

Emergency Contact: _____

Relationship to patient: _____ Phone: _____

DENTAL INSURANCE INFORMATION (PRIMARY)

Name of Subscriber: _____ Member ID: _____

Insurance Company: _____ SSN#: _____

Employer of Subscriber: _____ Group Number: _____

D.O.B. of Subscriber: _____

DENTAL INSURANCE INFORMATION (SECONDARY)

Name of Subscriber: _____ Member ID: _____

Insurance Company: _____ SSN#: _____

Employer of Subscriber: _____ Group Number: _____

D.O.B. of Subscriber: _____

I hereby authorize and request dental services be performed to myself or for my dependents. I give my consent to Dr. Michael T. Nykamp and supervised staff, to complete any procedures and treatment found necessary for my health. Although, the office will submit my insurance claims for payment, I agree that I am financially responsible for any charges on my account, regardless of insurance reimbursement. Furthermore, I give permission for the office to give my information to my insurance company regarding pre-treatment estimates and treatment completed. To the best of my knowledge, all the provided information is true and correct.

Signature: _____ Date: _____

Dental History:

Check (✓) if you are currently experiencing any of the following:

☐ Bad Breath	☐ Dental Anxiety	☐ Loose Teeth
☐ Bleeding Gums	☐ Emergency Care	☐ Periodontal Treatment
☐ Broken Teeth	☐ Grinding Teeth	☐ Sensitivity
☐ Clicking/Popping Jaw	☐ Jaw Pain	☐ Sore/Growth

Are you satisfied with your smile? ☐ YES ☐ NO

Medical History:

Check (✓) if you have or have experienced any of the following:

If nothing below applies to you, please check NONE.

☐ Anemia	☐ Diabetes	☐ Pre-Medication
☐ Alzheimer's	☐ Fainting	☐ Radiation Treatment
☐ Artificial Joints	☐ Glaucoma	☐ Respiratory Disease
☐ Arthritis	☐ General Anxiety	☐ Rheumatism
☐ Artificial Heart Valves	☐ Heart Murmur	☐ Scarlet Fever
☐ Asthma	☐ Heart Problems	☐ Seizures
☐ Back Problems	☐ Headaches	☐ Stroke
☐ Blood Disease	☐ Hemophilia	☐ Skin Rash
☐ Blood Transfusion	☐ Hepatitis	☐ Swelling Feet/Ankle
☐ Cancer	☐ HIV/AIDS	☐ Tonsilitis
☐ Chemical Dependency	☐ High Blood Pressure	☐ Thyroid Problems
☐ Chemotherapy	☐ Kidney Disease	☐ Tuberculosis
☐ Chest Pain	☐ Liver Disease	☐ Tobacco Habit
☐ Circulatory Problems	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Cough up Blood	☐ Osteoporosis	☐ Venereal Disease
☐ Cortisone Treatment	☐ Pacemaker	☐ NONE
☐ Dementia	☐ Persistent Cough	

Women:		
Are you Pregnant?	Nursing?	Taking Birth Control?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Taking any medications? ☐ YES ☐ NO

If YES, please list all / attach list:

_____

Any allergies? ☐ YES ☐ NO

If YES, please list all:

_____

Any Serious Illness/Operation:

_____

Primary Physician: _____ Last Exam: ____/____/____