

Milestone, Inc.  
Milestone Dental Clinic  
Patient History

Date Completed: \_\_\_\_\_

**Patient Information**

Full Legal Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Private Dental Insurance see below**

Social Security #: \_\_\_\_\_

Public Aid ID#: \_\_\_\_\_

**PLEASE PROVIDE COPY OF DENTAL INSURANCE CARD AND/OR MEDICAID CARD AT THE TIME OF EACH APPT.**

**Legal Guardian/Guarantor**

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Bus. Phone: \_\_\_\_\_

\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

**Care Agency:**

Please Indicate: \_\_\_\_\_ Direct care \_\_\_\_\_ Indirect care

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Fax: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Email: \_\_\_\_\_

**Primary Physician**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_

Date of last exam: \_\_\_\_\_

**Private Dental Insurance- (if none skip)**

PPO or HMO: \_\_\_\_\_

Name of Subscriber and mailing address for claims \_\_\_\_\_

\_\_\_\_\_

Subscriber ID and SSN \_\_\_\_\_

Date of birth of subscriber: \_\_\_\_\_

Group Number: \_\_\_\_\_

Phone Number for Benefit Verification: \_\_\_\_\_

When possible please provide copy (front & back) of dental insurance card(s)

Please return completed forms to

Milestone Dental Clinic

275 N. Phelps Ave.

Rockford, IL 61108

(815) 484-8678

(815) 484-8680 Fax

**PLEASE PROVIDE A COPY OF THE PATIENT'S MOST RECENT YEARLY PHYSICAL EXAM  
ALWAYS PROVIDE CURRENT MEDICATION LIST AT EACH APPOINTMENT**

**PATIENT PROFILE**

Patient Name: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Hearing Impaired: Yes or No

Visually Impaired: Yes or No

Sex Male or Female

Wheelchair: Yes or No

Does patient have meaningful speech? **Yes or No**

Describe degree and nature of disability and functional level of patient. (Example: mental age, care needs, disability cause, and diagnosis)

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List present medications and their doses and frequencies. (DO NOT LEAVE BLANK)

**Please note, only sedation orders written by Milestone Dentists are to be administered to patients. Any pre-existing sedation orders need to be discontinued prior to the start of treatment here.**

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If patient is allergic to any medications, local anesthesia, foods, latex etc. Please list what they are allergic to and the reaction.

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Has patient been hospitalized in the last 5 years? **Yes or No** If yes, for what and when? \_\_\_\_\_

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Describe any serious trouble the patient has had with previous dental treatment (including behavioral, aggression, sedation, bleeding, vomiting, biting):

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Suggestions for positive reinforcers: (i.e.: stickers, coins, etc.)

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Date of last dental treatment? \_\_\_\_\_

Who was the dentist? \_\_\_\_\_

What was the treatment? \_\_\_\_\_

Reason for leaving that dental office? \_\_\_\_\_

Does the patient have any oral habits? (Finger sucking, hand biting, chewing on objects, grinding of teeth, chewing on clothes, eating of non-edibles, smoking, biting, etc.)

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Name: \_\_\_\_\_

Who is responsible for brushing the patient's teeth? \_\_\_\_\_  
How many times a day? \_\_\_\_\_

Any recent weight gain or loss? **Yes or No**

Is the patient on a special diet? **Yes or No**

What kind? \_\_\_\_\_

Does the patient have a feeding tube? **Yes or No**

Does the patient require assistance with feeding? **Yes or No**

Does the patient gag or vomit easily? **Yes or No**

Explain: \_\_\_\_\_

Does the patient smoke or use tobacco products? **Yes or No**      How many years? \_\_\_\_\_

Does the patient wear any removable appliances or dentures? **Yes or No**

What? \_\_\_\_\_      Age of the appliance? \_\_\_\_\_

**Circle any of the following, which the patient has or has had in the past?**

- |    |                                     |    |  |
|----|-------------------------------------|----|--|
| 1  | Mental retardation                  | 22 | Mitral Valve Prolapse                    |
| 2  | Autism                              | 23 | Heart surgery                            |
| 3  | Seizures                            | 24 | Heart Dysfunction- Please give details   |
|    | When was the last seizure? _____    | 25 | Pacemaker                                |
|    | How long did it last? _____         | 26 | High/low Blood Pressure                  |
|    | What type of seizure? _____         | 27 | Shunt for fluid on the Brain             |
|    | How many per day? _____             |    | Type VA or VP                            |
| 4  | Down Syndrome                       | 28 | Oral Sores (including herpes)            |
| 5  | Cerebral Palsy                      | 29 | Venereal disease                         |
| 6  | Traumatic Brain Injury              | 30 | AIDS/HIV +                               |
|    | When? Cause? _____                  | 31 | Blood Disorders (Type?) _____            |
| 7  | Stroke/CVA                          | 32 | Steroid Medications                      |
| 8  | Liver disease                       | 33 | Pneumonia                                |
| 9  | Hepatitis                           | 34 | Depression                               |
| 10 | Kidney disease                      | 35 | Schizophrenia                            |
| 11 | Diabetes                            | 36 | Post Traumatic Stress Disorder           |
| 12 | Breathing problems                  | 37 | Intermittent Explosive Disorder          |
| 13 | Asthma                              | 38 | Attention Deficit Hyperactivity Disorder |
|    | How often do you use inhaler? _____ | 39 | Tourette's Syndrome                      |
| 14 | Thyroid disease                     | 40 | Cancer (Chemo? Radiation?)               |
| 15 | Tuberculosis                        | 41 | Physical/sexual abuse                    |
| 16 | Arthritis                           | 42 | Substance abuse                          |
| 17 | Limited joint movement              | 43 | MRSA+                                    |
| 18 | Artificial joints (i.e. knee, hip)  | 44 | Stomach ulcers                           |
|    | Date of placement _____             | 45 | Gastro-esophageal reflux disease         |
| 19 | Heart Murmur                        |    |  |
| 20 | Rheumatic Fever                     |    |  |
| 21 | Artificial Heart Valve              |    |  |

Please add any other information concerning this patient's medical or mental health, which we should know.

\_\_\_\_\_  
Signature- Relationship to patient