

TONIANN CONTE, DMD

PATIENT MEDICAL HISTORY & INFORMATION

PLEASE PRINT

NAME _____ DATE OF BIRTH ____/____/____

SOC. SEC. # _____ or ID # _____ MALE ___ FEMALE ___

LOCAL ADDRESS _____ CITY/STATE _____ ZIP _____

OTHER ADDRESS _____ CITY/STATE _____ ZIP _____

SPOUSE NAME _____ HOME PHONE _____

YOUR PLACE OF EMPLOYMENT _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ CITY/STATE/ZIP _____

NAME OF PHYSICIAN _____ PHYSICIAN PHONE _____

DATE OF LAST DENTAL VISIT _____ REASON FOR TODAY'S VISIT _____

DO YOU HAVE ANY OF THE FOLLOWING?
(IF YES, PLEASE CIRCLE)

- HIGH BLOOD PRESSURE, DIABETES, ASTHMA,
- TUBERCULOSIS, KIDNEY OR LIVER DISEASE,
- BLOOD DISEASE, ARTHRITIS, EAR TROUBLE,
- ANEMIA, RHEUMATIC FEVER, HEART MURMUR,
- MITRAL VALVE PROLAPSE, PACEMAKER, STROKE,
- HEART-BY-PASS, JOINT REPLACEMENT DATE: _____
- EMPHYSEMA, ACQUIRED IMMUNE DEFICIENCY SYNDROME

PLEASE INDICATE WITH YES NO

IN THE LAST YEAR:

*HAVE YOU HAD FULL MOUTH X RAYS _____

*HAVE YOU EVER HAD ANY SKIN SENSITIVITY TO JEWELRY? _____

*ARE YOU SENSITIVE OR ALLERGIC TO ANY MEDICATIONS, ANESTHETICS, OR METALS? _____

*IF YES, WHAT? _____

*SUBJECT TO PROFUSE BLEEDING? _____

*UNDER A PHYSICIAN'S CARE? _____

IF YES, FOR WHAT PURPOSE? _____

LIST ALL MEDICATIONS CURRENTLY TAKEN INCLUDING HERBAL MEDICATIONS:

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY _____

GROUP NO. _____

EMPLOYEE _____

EMPLOYER _____

SS# or ID# _____ DATE OF BIRTH _____

PRE-MEDICATION PRIOR TO DENTAL APPT'S?
PLEASE LIST:

- WOMEN
ARE YOU TAKING BIRTH CONTROL PILLS?
YES ___ NO ___

WHO MAY WE THANK FOR REFERRING YOU?

ARE YOU PAYING BY: CHECK ___ CASH ___ CREDIT CARD ___
WE ACCEPT VISA MASTERCARD, DISCOVER & DEBIT

SIGNATURE _____

DATE _____