

**MEDICAL HISTORY**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury? Yes No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? Yes No \_\_\_\_\_

Are you on a special diet? Yes No \_\_\_\_\_

Do you use tobacco? Yes No \_\_\_\_\_

Do you use controlled substances? Yes No \_\_\_\_\_

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Renal Dialysis	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Rheumatic Fever	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Rheumatism	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Scarlet Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Shingles	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	Hives or Rash	Yes No	Sickle Cell Disease	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hypoglycemia	Yes No	Sinus Trouble	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Irregular Heartbeat	Yes No	Spina Bifida	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Kidney Problems	Yes No	Stomach/Intestinal Disease	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Leukemia	Yes No	Stroke	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Liver Disease	Yes No	Swelling of Limbs	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Lung Disease	Yes No	Tonsillitis	Yes No
Cancer	Yes No	Glaucoma	Yes No	Mitral Valve Prolapse	Yes No	Tuberculosis	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Congenital Heart Disorder	Yes No	Heart Pace Maker	Yes No	Radiation Treatments	Yes No	Yellow Jaundice	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Recent Weight Loss	Yes No		

Have you ever had any serious illness not listed above? Yes No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## ABOUT YOU

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

I prefer to be called \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Single    Married    Divorced    Widowed

Home # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Driver's License # \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation \_\_\_\_\_

Where and when are the best times to reach you?  
\_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

Last Dental Visit \_\_\_\_\_

## SPOUSE INFORMATION

His/Her Name \_\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Cell#(\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ CDL# \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

\_\_\_\_\_

Billing Address \_\_\_\_\_

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

SS# \_\_\_\_\_ CDL# \_\_\_\_\_

Employer \_\_\_\_\_

Work # ( ) \_\_\_\_\_ Cell# ( ) \_\_\_\_\_

## INSURANCE COVERAGE

### Primary

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_) \_\_\_\_\_

Group or Plan # \_\_\_\_\_

Insured's Name \_\_\_\_\_

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

Insured's Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Insured's Employer \_\_\_\_\_

### Secondary

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_) \_\_\_\_\_

Group or Plan # \_\_\_\_\_

Insured's Name \_\_\_\_\_

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

Insured's Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Insured's Employer \_\_\_\_\_

In the event of an emergency, is there someone who lives near you that we should contact?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ Wk# (\_\_\_\_) \_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal Physician?    Yes    No

Physician's Name \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Date of last visit \_\_\_\_\_

Are you currently under the care of a physician?    Yes    No

Please explain \_\_\_\_\_

Please continue on reverse.....