Patient's Information

Everlast Dental

Patient Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Birthday / /
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow	☐ Male ☐ Female	Driver's License and State
Primary Ins. Company	Group	Subscriber
Secondary Ins. Company	Group	Subscriber

Responsible Party

Name	Social Security Number	Home Phone
Home Address	City State Zip	Birthday / /
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City State Zip	
Spouse's Name	Social Security Number	Birthday / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City State Zip	

Patient's Medical History

I consider my health to be (please check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of following? Please circle **Y** for yes or **N** for no

1	Y	N	Heart disease	22	Y	N	Liver Disease	36	Y	N	AIDS/HIV
2	Y	N	Heart Murmur/Mitral Valve Prolapse	23	Y	N	Jaundice				
3	Y	N	Stroke	24	Y	N	Hepatitis Type				
4	Y	N	Congenital Heart Lesions	25	Y	N	Diabetes				
5	Y	N	Rheumatic Fever	26	Y	N	Excessive Urination and/or Thirst				
6	Y	N	Abnormal Blood Pressure	27	Y	N	Infectious Mononucleosis ("Mono")				
7	Y	N	Anemia	28	Y	N	Herpes				
8	Y	N	Prolonged Bleeding Disorder	29	Y	N	Arthritis				
9	Y	N	Tuberculosis or Lung Disease	30	Y	N	Sexually Transmitted Venereal Diseases				
10	Y	N	Asthma	31	Y	N	Kidney Disease	37	Y	N	Immune Suppressed Disorder
11	Y	N	Hay Fever	32	Y	N	Tumor or Malignancy	38	Y	N	Hearing Loss
12	Y	N	Sinus Trouble	33	Y	N	Cancer/Chemotherapy	39	Y	N	Fainting Spells
13	Y	N	Epilepsy/Seizures	34	Y	N	Radiation/Therapy	40	Y	N	Glaucoma
14	Y	N	Ulcers	35	Y	N	History of Drug Addiction	41	Y	N	History of Emotional or Nervous Disorders
15	Y	N	Implants/Artificial Joints: Hip-Knee								**Women**
16	Y	N	I smoke or use chewing tobacco. If yes, how much per day? How many years?					42	Y	N	Are you taking birth control medication?
17	Y	N	I have consumed alcohol within the last 24 hours.					43	Y	N	Are you or could you be pregnant or nursing?
18	Y	N	I usually take an antibiotic prior to dental treatment.								
19	Y	N	Have you ever taken Fen-Phen or Redux?								
20	Y	N	I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____.								
21	Y	N	Do you have any other medical problem or medical history NOT listed on this form?								

Doctor Notes Only:

Are you allergic to any of the following?

44	Y	N	Aspirin / Ibuprofen
45	Y	N	Sulfa Drugs/Sulfites/Sulfides
46	Y	N	Penicillin
47	Y	N	Codeine
48	Y	N	Latex, Metals, Plastics
49	Y	N	Local Anesthetics (Novocaine)
50	Y	N	Other Medications Which ones?

Please list all medications you are currently taking _____

_____

_____

_____

Physician's Name _____ Phone _____

Address _____ Fax _____

Medical health reviewed by:

x _____ Date _____

Doctor's Signature

x _____ Date _____

Patient's Signature

x _____ Date _____

If patient is a Minor, Parent/Guardian Signature

Periodic Medical Update

☐ No change ☐ Update: _____ Patient's Initial _____ Date _____ Dr's Initial _____.

☐ No change ☐ Update: _____ Patient's Initial _____ Date _____ Dr's Initial _____.

☐ No change ☐ Update: _____ Patient's Initial _____ Date _____ Dr's Initial _____.