Medical History

Patient's Name ____

Physician's Name & Phone____________________________ Date of Last Physical____________

Have you ever had any of the following? (check boxes that apply)

□ Heart Problems	□ Chemical Dependency	□ Nervous Problems	□ Psychiatric Care
□ High Blood Pressure	□ Hemophilia	□ Radiation Treatment	□ Chronic Diarrhea
□ Infective Endocarditis	□ Arthritis	□ Back Problems	□ General Allergies
□ Sinus Problems	□ Epilepsy	□ Diabetes	□ Blood Disease
□ A.I.D.S.	□ Headaches	□ Respiratory Disease	□ Cancer
□ Stroke	□ Artificial Heart Valves	□ Special Diet	□ Circulatory Problems
□ Ulcer	□ Joint Replacement	□ Swollen Neck Glands	□ Allergies to Anesthetics
□ Immunosuppressive Disorders	□ Low Blood Pressure	□ Hepatitis or Liver Disease	

In the past, have you been required to take antibiotics prior to dental treatment for a reason other than infection? □ Yes □ No

If so, for what condition?____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? □ Yes □ No

If so, what?____

Have you ever responded adversely to medical or dental treatment? □ Yes □ No

If so, what?____

Have you ever or are you taking Osteoporosis or cancer medication? □ Yes □ No

If so, for what? ____

Have you ever or are you taking an oral or IV Bisphosphonate? (ie. Actonel, Boniva, Fosamax, Didronel) □ Yes □ No

If so, what?____

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

If so, for what? ____

Are you taking any medications at this time? Please list name and dosage of each. Please use additional sheet if needed.

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____

(Women) Do you suspect that you are pregnant? □ Yes □ No Are you nursing? □ Yes □ No

Is there anything else we should know about your medical history?

____

____

____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ______________________________ Date______________

DOCTOR USE ONLY

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Patient Registration and Medical History

Date ______________________________

Patient's Name ____ Preferred Name ________________________________

Home Phone________________________ Work Phone_______________________ Cell Phone______________________

What is your preferred method for appointment reminders? □ Postcard □ Email___________________ □ Phone □ Text

Mailing Address____ City___________________ State_____ Zip___________

Permanent Address______________________________________ City___________________ State_____ Zip___________

Sex: □ Male □ Female Age _______ Date of Birth __________________ □ Single □ Married □ Widowed □ Divorced

Employed by ______________________________ Occupation_______________________________ SS#________________

Student: □ Yes □ No Name of School____________________________________ City___________________ State_____

Spouse Name___________________________ Employed by__________________________ Business Phone____________

In case of emergency, whom should be notified?__________________________________ Phone_____________________

If you are new to our office, whom may we thank for referring you?____

Insurance Information

Who is the responsible party for this account?____

Responsible Party Address____________________________________ City_______________ State_______ Zip_________

SSN ______________________________ DOB _____________________________ Phone _____________________________

Employed By____ Occupation ____

Dental Insurance Company ____ Phone_________________________

Subscribers Name ____

Subscribers DOB ___________________________ Subscribers SSN ____

Subscribers Identification Number_______________________________________ Group Number______________________

Subscribers Place of Employment ____

Subscribers Address ____

Secondary Insurance Company ____ Phone_________________________

Subscribers Name ____

Subscribers DOB ___________________________ Subscribers SSN ____

Subscribers Identification Number_______________________________________ Group Number______________________

Subscribers Place of Employment ____

Subscribers Address ____