

PATIENT INFORMATION

CONFIDENTIAL

DATE _____

(PLEASE PRINT)

SS# _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____ WOULD YOU LIKE NOTICES SENT BY EMAIL? Y N CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

EMPLOYER _____ WORK PHONE _____

NAME OF PERSON RESPONSIBLE/INSURED FOR ACCOUNT _____ SS# _____ D.O.B. _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

PRIMARY INSURANCE CO. _____ SECONDARY _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

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|---|--|--------------------------|--------------------------|--------------------------|--------------------------|-----|----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------|--|--------------|--|---------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------------|--|-----------|--|-------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------|--|--------|--|-------|--|--------------------------|--------------------------|--------------------------|--------------------------|-------|--|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, what medication(s) are you taking? _____</p> <p>4. Do you use tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Do you use alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Do you use cocaine or other drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>7. Are you allergic to or have you had any reactions to the following?</p> <table border="0"> <tr> <td>YES</td><td>NO</td><td>YES</td><td>NO</td><td>YES</td><td>NO</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Local Anesthetics (eg. novocaine)</td> <td colspan="2">Barbiturates</td> <td colspan="2">Aspirin</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Penicillin or other antibiotics</td> <td colspan="2">Sedatives</td> <td colspan="2">Other</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Sulfa drugs</td> <td colspan="2">Iodine</td> <td colspan="2">_____</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td colspan="2">_____</td> </tr> </table> <p>8. WOMEN ONLY: YES NO</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c) Are you taking birth control pills? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | YES | NO | YES | NO | YES | NO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. novocaine) | | Barbiturates | | Aspirin | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other antibiotics | | Sedatives | | Other | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs | | Iodine | | _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |
| YES | NO | YES | NO | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Local Anesthetics (eg. novocaine) | | Barbiturates | | Aspirin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Penicillin or other antibiotics | | Sedatives | | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sulfa drugs | | Iodine | | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

9. Do you have or have you had any of the following?

- | | | |
|--|--|---|
| YES NO | YES NO | YES NO |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Easily Winded |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever/MVP | <input type="checkbox"/> <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> <input type="checkbox"/> Hay Fever / Allergies |
| <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Fainting / Seizures | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement or Implant | <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> Leukemia | <input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> <input type="checkbox"/> Prescription Weight Loss Medication |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles/ Ulcers | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> <input type="checkbox"/> Chest Pains/Angina | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Problem | | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | | _____ |

COMMENTS

Signature of Dentist _____ Date _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered correctly. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents at time of services.

Signature _____ Date _____