Patient Medical History

Patient's Name_____ Date of Birth _____

Patient's Address _____

City, State, Zip Code _____

Home Phone_____ Work Phone _____ Single__ Married__ Divorced__ Widowed__

Cell Phone_____ Email _____

Social Security Number_____ Referred by _____

Place of Employment _____ Dental Insurance Coverage - Yes (Single/Dual) or No

Name of Dental Insurance(s)_____ Group Number(s) _____

How did you hear about our dental office?_____

If you are a new patient, date of last dental visit _____ Any X-rays taken? - Yes or No

What treatment was given? _____

Have you ever been hospitalized? If so, when and for what reason? _____

Are you currently under treatment? If so, what for? _____

Name of Physician(s) _____

Are you taking or have you ever taken medicine for bone health or cancer, such as (Bisphosphonates)

(Boniva) (Denosumab) (Fosamax)? Yes or No If yes, what medication?_____

Are you taking any medications at this time? Yes or No If yes, what are they? _____

_____

Are you allergic to any medications? Yes or No If yes, circle or list other medications.

Aspirin - Penicillin - Codeine - Erythromycin - Local Anesthesia - Epinephrine - Fluoride

Latex - Metals - Tetracycline - Sulfa's

Other allergies - _____

Name of Pharmacy_____ Phone _____

Females - Are you pregnant? - Yes or No Are you taking birth control pills? - Yes or No

Have you ever had any of the following?

__HIV/AIDS
__Heart Murmur
__Heart Problems
__Heart Disease/Stroke
__Rheumatic Fever
__Scarlet Fever
__High/Low Blood Pressure
__Artificial Heart Valve
__Anemia
__Prolonged Bleeding/ Blood Transfusions
__Emphysema
__Asthma
__Tumors/Abnormal Growths
__Hiatal Hernia
__Parkinson's Disease
__Psychiatric Treatment
__Cancer
__Chemotherapy/ Radiation Treatment
__Osteoporosis
__Sinus Problems
__Kidney Disease
__Liver Disease/Hepatitis (type)___
__Drug/Alcohol Dependency
__Venereal Disease
__Hyper/Hypo-Thyroid
__Hormone Replacement Therapy
__High Cholesterol
__Diabetes
__Pacemaker
__Anti-Depressants
__Digestive Disorders/Ulcers
__Arthritis/Artificial Joints
__Glaucoma
__Contact Lenses
__Head/Neck Injuries
__Epilepsy/Seizures
__Frequent Headaches
__Smoke/Chew Tobacco
__Viral Infections/Cold Sores
__Any Lumps or Swellings in Mouth
__Hives or Skin Rash
__Tuberculosis
__Lupus

*********PLEASE COMPLETE THE OTHER SIDE OF THIS FORM*********

Do you have any other medical conditions that are not on this list? - Yes or No

If yes, please list:

1. _____
2. _____
3. _____
4. _____

Do you have any special needs that we should be informed of? - Yes or No

If yes, please explain - _____

Person(s) to whom my dental information may be disclosed:

Name of persons(s):

1. _____
2. _____
3. _____
4. _____

I consent to the taking of x-rays and photographs before, during and after treatment.

I acknowledge that I am financially responsible for any balances due at the time that treatment is rendered.

If applicable - I hereby authorize the release of x-rays and any other pertinent information for my dental insurance provider that may be necessary in determining policy benefits for treatment rendered.

Patient's Signature_____ **Today's date** _____

If applicable - Patient's Representative's Signature _____