Personal Information and Medical History Form

Patient Information ***(confidential)*** ***Date***_____

Last Name_____First Name_____M.I._____

Preferred Name_____Referred by_____

Status: Married/Single/Divorced/Widow Sex: F M Spouse's Name_____

Birthdate:_____/_____/_____ Social Security #_____

Address_____City_____State_____ZIP_____

Appointment Confirmation will be via an email and text message. Phone confirmations are only available for those patients who have no email address or mobile phone. 24 hour notice is requested for cancellations.

Email Address_____

Mobile#_____Home Phone#_____Work#_____EXT_____

Employer_____Occupation_____School_____

Emergency Contact Name_____Contact#_____

Responsible Party for this account:

Last Name_____First Name_____M.I._____
Mobile#_____Home Phone#_____Work#_____EXT_____
(Enter data that is different from patient's address)
Address_____City_____State_____ZIP_____
Relationship to Patient: Spouse Mother Father StepParent Grandparent Guardian
Birthdate:_____/_____/_____ Social Security #_____
Employer_____Occupation_____School_____

Insurance Information for this account:

PRIMARY INSURANCE
Subscriber Name as it appears on card:_____
Relationship to Patient: Spouse Mother Father StepParent Grandparent Guardian
Employer_____Work#_____
Birthdate:_____/_____/_____ Social Security #_____
Insurance Company_____Subscriber I.D.#_____Group#_____
Insurance Address_____ City_____State_____ZIP_____
Insurance Telephone Contact#_____

SECONDARY INSURANCE
Subscriber Name as it appears on card:_____
Relationship to Patient: Spouse Mother Father StepParent Grandparent Guardian
Employer_____Work#_____
Birthdate:_____/_____/_____ Social Security #_____
Insurance Company_____Subscriber I.D.#_____Group#_____
Insurance Address_____ City_____State_____ZIP_____
Insurance Telephone Contact#_____

Patient Medical History **2014**

Physician Name_____**Physician Office Phone#**_____**Date of last exam**_____

Are you under medical treatment? Y N
Have you ever been hospitalized for any surgery or serious illness? Y N
Are taking any medications? Y N
If yes, list all medications:
_____
_____
_____

Do you use alcohol? Y N
Do you use tobacco? Y N
Have you ever been treated for osteoporosis? Y N
Y N

Women ONLY:
Are you pregnant? Y N
Do you think you might be pregnant? Y N
Are you taking contraceptives/hormones? Y N

Weight_____**Height**_____

Are you allergic or have you had any reaction to:

Local Anesthetic	Y N	Codeine	Y N
Penicillin	Y N	Any Metal	Y N
Erythromycin	Y N	Aspirin	Y N
Tetracycline	Y N	Latex	Y N
Other Antibiotics	Y N	Barbiturates	Y N
Sedatives	Y N		
Sulfa Drugs	Y N		

Other:_____
_____
_____

Rheumatic Fever	Y N	Abnormal Bleeding	Y N	AIDS or HIV	Y N	Allergies/Hay Fever/Sinusitis	Y N
Heart Disease	Y N	Anemia	Y N	Sexually Transmitted Disease	Y N	Arthritis/Rheumatoid	Y N
Heart Attack	Y N	Leukemia	Y N	Thyroid Problem	Y N	Disruptive Snoring	Y N
High Blood Pressure	Y N	Stroke	Y N	Hepatitis/Jaundice	Y N	Recent Weight Loss	Y N
Low Blood Pressure	Y N	Cancer	Y N	Liver Disease	Y N	Swollen Ankles	Y N
Heart Murmur	Y N	Radiation	Y N	Asthma	Y N	**Prosthetic Joint Replacement:**	
Inborn Heart Defect	Y N	Chemotherapy	Y N	COPD/Respiratory	Y N	Date Replaced_____	
Heart Valve Replaced	Y N	Diabetes	Y N	Emphysema	Y N	Physician Who Replaced_____	
Angina or Chest Pain	Y N	Epilepsy/Convulsions	Y N	Tuberculosis	Y N	Identify Which Joint_____	
Pacemaker/Defibrillator	Y N	Fainting/Seizures	Y N	Renal/Kidney Disease	Y N	Premedication Needed	Y N
Stents	Y N	Stomach Issues	Y N				
Deep Vein Thrombosis	Y N	Ulcers	Y N				

Patient Dental History

Premedication Prior to Tx	Y N	Difficult Tooth Extractions	Y N	Difficulty Closing Jaw	Y N
Oral Herpes/Apthous Ulcers	Y N	Prolonged Bleeding Following Tooth Extractions	Y N	Difficulty Opening Jaw	Y N
Oral Sores/Lumps/Bumps	Y N	Jaw Pain/TMJ issues relating to:	Y N	Difficulty Chewing Food	Y N
Tooth Pain/issues	Y N	Joint Ear Side of Face		Head, Neck or Jaw Injuries	Y N
Tooth Sensitivity	Y N	Headaches in the Morning	Y N	Orthodontic Treatment	Y N
Gingival/Gum Bleeding	Y N	Teeth Clenching or Grinding	Y N	Orthodontist_____	

Consent for Dental Treatment and Release of Information

I authorize consent for dental treatment in this office. I certify that I have read and understand the above information to the best of my knowledge.The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners. I acknowledge that upon the disclosure of dental record information to an insurance company or other payer pursuant to this authorization, all dentists in this office are no longer responsible for the confidentiality of any information known or possessed by the payer. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. 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 dependent's behalf, regardless of my dental insurance benefits.

I have been provided access to the Notice of Privacy Practices.

Name_____Date_____