## 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) Preferred Pharmacy_____

□ Acid Reflux
□ AIDS/HIV
□ Anesthetic Sensitivity
□ Arthritis
□ Artificial Heart Valve
□ Back Problems
□ Blood Clotting Disorder/ Hemophilia
□ Blood Thinning Medication
□ Cancer
□ Chemical Dependency
□ Circulatory Problems
□ Diabetes __Type 1 __Type 2
□ Epilepsy
□ General Allergies
□ GI Problems or Surgery
□ Headaches
□ Heart Problems
□ Hepatitis or Liver Disease
□ High Blood Pressure
□ Immunosuppressive Disorder
□ Infective Endocarditis
□ Joint Replacement, please explain_____
□ Latex Allergy
□ Psychiatric Care
□ Radiation - Head or Neck
□ Respiratory Disease
□ Sinus Problems
□ Special Diet
□ Stroke
□ Swollen Neck Glands
□ Tuberculosis
□ Ulcer

Do you have neurostimulator or pacemaker/defibrillator? □ Yes □ No

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.

_____

_____

(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 (including any surgeries)?

_____

_____

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_____

## 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, who should be notified?_____ Phone_____

If you are new to our office, who may we thank for referring you?_____

Who is the responsible party for this account?_____

Responsible Party Address_____ City_____ State_____ Zip_____

SSN _____ DOB _____ Phone _____

Employed By_____ Occupation _____

## Insurance Information

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 _____