CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM Date_____

PATIENT NAME (Last, First, Middle): _____ TITLE: _____

ADDRESS: _____CITY_____ST_____ZIP_____

HOME PHONE: ( ) _____ WORK: ( ) _____ CELL: ( ) _____

BIRTH DATE _____/_____/_____ S.S.# _____/_____/_____ How did you hear about us?_____

SEX (PLEASE CIRCLE): M F MARITAL STATUS (circle one): Single Married Divorced Widowed

EMAIL: _____

MEDICAL ALERTS: _____

_____

Date of Last Physical Exam: _____/_____/_____ Date of Last Dental Exam: _____/_____/_____

1. Are you now or have you recently been under a physician's care? _____ Yes _____ No

Reason: _____

2. Have you ever been a patient in a hospital or had any serious illness?

Explain: _____

ALLERGIES

3. Are you allergic to or do you suffer ill effects from any of the following?

YES	NO		YES	NO		YES	NO	
____	____	Penicillin	____	____	Codeine	____	____	Dental Anesthesia
____	____	Erythromycin	____	____	Latex	____	____	Bleach

Please list any other allergies you may have: _____

_____

4. Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
____	____	Arthritis	____	____	Hepatitis or Jaundice	____	____	Bleeding Problems
____	____	Rheumatic Fever	____	____	Liver Disease	____	____	Fainting Tendency
____	____	Heart Trouble	____	____	Cancer or Tumor	____	____	Epilepsy
____	____	Heart Murmur	____	____	Tuberculosis	____	____	Thyroid Disease
____	____	High/Low Blood Pressure (please circle one)	____	____	Diabetes	____	____	Glaucoma
____	____	Chest Pain	____	____	Kidney/Bladder Trouble	____	____	Radiation Treatment
____	____	Stroke	____	____	Anemia	____	____	Psychiatric Disorders
____	____	Shortness of Breath	____	____	Lung Disease	____	____	HIV or AIDS
____	____	Asthma or Hay Fever	____	____	Venereal Disease	____	____	Prosthetic Joint Replacement
____	____	Sinus Trouble	____	____	Blood Disease	____	____	Blood Transfusion
____	____	Severe Head Injury	____	____	Emphysema	____	____	Ulcers

5. Check any of the following that you are taking or have taken:

YES	NO		YES	NO		YES	NO	
____	____	Steroids	____	____	Blood Thinners	____	____	Sedatives
____	____	Osteoporosis medications						

6. Are you taking any other medication? ____ YES ____ NO Please list: _____

_____

7. Have you ever been asked to **pre-medicate** before dental appointments for the following conditions? (Circle all that apply):

Cyanotic Congenital Heart Disease Cardiac Transplant Artificial Heart Valves History of Infective Endocarditis

Prosthetic Joint Replacement Other:_____

Women Only:

Are you pregnant? ____ Yes ____ No If yes: How many months? _____ Are you breast feeding? _____

***PLEASE NOTE:** If you are taking any kind of birth control pills, shots or implants, hormone therapy, etc., please indicate these medications in question #6.

FINANCIALLY RESPONSIBLE PARTY FOR PATIENT

<u>This form must be filled out completely</u>. NOTE: if the person financially responsible for your bill is someone other than a guardian or spouse, we will need to call and verify authorization from this person or business prior to any treatment being performed.

If you have dental insurance, please fill out section I. If you do not have dental insurance, please fill out section II.

Section I.

GUARANTOR INSURED'S NAME (This is also the person responsible for payment of any co-pays, co-insurance, and/or balances after insurance pays).

(Last, First, Middle): _____ TITLE: _____

ADDRESS: _____CITY_____ST_____ZIP_____

HOME PHONE: ( ) _____ WORK: ( ) _____ CELL: ( ) _____

S.S.# _____/_____/_____ D.O.B. _____/_____/_____ RELATIONSHIP TO PATIENT:_____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

DENTAL INSURANCE COMPANY: _____

(please provide your insurance card)

Section II.

PATIENT HAS <u>NO</u> INSURANCE. THE PERSON/BUSINESS BELOW IS RESPONSIBLE FOR PAYMENT.

(Last, First, Middle): _____ TITLE: _____

ADDRESS: _____CITY_____ST_____ZIP_____

HOME PHONE: ( ) _____ WORK: ( ) _____ CELL: ( ) _____

S.S.# _____/_____/_____ D.O.B. _____/_____/_____ RELATIONSHIP TO PATIENT:_____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____