PATIENT INFORMATION AND HEALTH HISTORY

Name _____ Date _____
Patient Social Security # _____ Birthdate _____ AGE _____
Address _____ Home # _____ Cell # _____
City _____ ST _____ Zip _____
Sex: M_____ F_____ Single_____ Married_____ Separated_____ Divorced _____ Widowed_____
Employer _____ Occupation _____
Business Address _____ Business Phone _____
Person Responsible for Account _____ Relationship to Patient _____
Social Security # _____ Birthdate _____
Address _____ Phone _____
City _____ ST _____ Zip _____
Policy Holder _____
Dental Insurance Company _____ Birthdate _____
Emergency # _____ Name _____ Relationship _____
Email _____ **Who Referred You?** _____

Please inform us if you are covered by more than one Dental Insurance Policy.

MEDICAL HISTORY

Physician's Name _____ Phone _____ Date of Last Physical _____

Do you have or have you ever had any of the following? (check boxes that apply):

- ☐ Heart Disease/Problems
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Chest Pains
- ☐ Swollen Ankles
- ☐ Easily Winded
- ☐ Circulatory Problems
- ☐ Low Blood Pressure
- ☐ Artificial Heart Valves/Pacemaker
- ☐ Joint Implant/Replacement
- ☐ Rheumatic Fever
- ☐ Respiratory Problems/COPD
- ☐ Sinus Problems
- ☐ Allergies to Dairy
- ☐ Allergies to other Medicine/Drugs
- ☐ Latex Allergy
- ☐ Arthritis
- ☐ Back Problems
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Headaches
- ☐ Migranes
- ☐ Blood Disorder
- ☐ Hemophilia
- ☐ Clotting Disorders
- ☐ Coumadin or Blood Thinners/ Aspirin Regiment
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Kidney Disease
- ☐ Epilepsy/Convulsions
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Alzheimer's Disease
- ☐ Psychiatric Care
- ☐ Chemical Dependency
- ☐ Nervous Problems
- ☐ Eating Disorders
- ☐ Recent Weight Loss
- ☐ Aids/HIV
- ☐ Immunosuppressive Disorders
- ☐ STD
- ☐ Stomach Trouble
- ☐ Ulcers
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Fosamax/Boniva or similar
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Sjogrens Syndrome

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what?

_____

Have you ever responded adversely to medical or dental treatment? _____

Are you under a physicians care? _____
Have you been hospitalized in the last 5 years? _____
If yes, please explain _____

_____

Are you taking any medication(s)? _____
If yes, please list _____

_____

Do you use tobacco? _____ How much? _____
Do you use controlled substances? _____

Women Only:

Are you pregnant or think you may be? _____
Are you nursing? _____ Taking Oral contraceptives? ____

Are you allergic or had any reactions to the following?

Please answer questions by checking YES or NO.	**YES**	**NO**
Local Anesthetics (eg. Novocaine)	____	____
Any Antibiotics	____	____
Sulfa Drugs	____	____
Barbiturates	____	____
Sedatives	____	____
Iodine	____	____
Aspirin	____	____
Any Metals (eg. nickel, mercury)	____	____
Latex Rubber	____	____
Other	____	____

OVER