# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | | |
|---|---|---|---|
| Are you under a physician's care now? | Yes | No | If yes, please explain: |
| Have you ever been hospitalized or had a major operation? | Yes | No | If yes, please explain: |
| Have you ever had a serious head or neck injury? | Yes | No | If yes, please explain: |
| Are you taking any medications, pills, or drugs? | Yes | No | If yes, please explain: |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes | No | |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes | No | |
| Are you on a special diet? | Yes | No | |
| Do you use tobacco? | Yes | No | |
| Do you use controlled substances? | Yes | No | |

Women: Are you
Pregnant/Trying to get pregnant? Nursing?
Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | |
|---|---|---|---|---|
| AIDS/HIV Positive | Chest Pains | Frequent Headaches | Hypoglycemia | Rheumatic Fever |
| Alzheimer's Disease | Cold Sores/Fever Blisters | Genital Herpes | Irregular Heartbeat | Rheumatism |
| Anaphylaxis | Congenital Heart Disorder | Glaucoma | Kidney Problems | Scarlet Fever |
| Anemia | Convulsions | Hay Fever | Leukemia | Shingles |
| Angina | Cortisone Medicine | Heart Attack/Failure | Liver Disease | Sickle Cell Disease |
| Arthritis/Gout | Diabetes | Heart Murmur | Low Blood Pressure | Sinus Trouble |
| Artificial Heart Valve | Drug Addiction | Heart Pacemaker | Lung Disease | Spina Bifida |
| Artificial Joint | Easily Winded | Heart Trouble/Disease | Mitral Valve Prolapse | Stomach/Intestinal Disease |
| Asthma | Emphysema | Hemophilia | Osteoporosis | Stroke |
| Blood Disease | Epilepsy or Seizures | Hepatitis A | Pain in Jaw Joints | Swelling of Limbs |
| Blood Transfusion | Excessive Bleeding | Hepatitis B or C | Parathyroid Disease | Thyroid Disease |
| Breathing Problem | Excessive Thirst | Herpes | Psychiatric Care | Tonsillitis |
| Bruise Easily | Fainting Spells/Dizziness | High Blood Pressure | Radiation Treatments | Tuberculosis |
| Cancer | Frequent Cough | High Cholesterol | Recent Weight Loss | Tumors or Growths |
| Chemotherapy | Frequent Diarrhea | Hives or Rash | Renal Dialysis | Ulcers |
| | | | | Venereal Disease |
| | | | | Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

# PATIENT REGISTRA TION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: Policy Holder Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

**First Name:** _____ **Last Name:** _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Other

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments: Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00