

MEDICAL HISTORY FORM

(Please Print)

Today's date (MM/DD/YYYY):						
PATIENT INFORMATION						
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Patient's last name	First	Middle	Birth date	Age	Gender
				/ /		<input type="checkbox"/> F <input type="checkbox"/> M
Name you like to be called?		Do you play a musical instrument?		If YES, which instrument?		
		<input type="checkbox"/> NO <input type="checkbox"/> YES				
Mailing Address			City	State	ZIP	
Home Phone		Work Phone		Cell Phone	Email address	
() -		() -		() -		
Employer		No. of years employed		Occupation		Social Security No.
						- -
How did you hear about our office?		<input type="checkbox"/> Dr.		<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Website/Internet
<input type="checkbox"/> Insurance	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other:			
Other family members seen here:						
Who may we thank for referring you to our office?						
RESPONSIBLE PARTY				<input type="checkbox"/> SAME AS ABOVE		
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last Name	First	Middle	Marital Status		
				<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Social Security No.		Date of Birth	Home Phone	Work Phone	Cell Phone	
- -		/ /	() -	() -	() -	
Address				State	ZIP	Years at this address
Mailing Address (if different from above)					State	ZIP
Previous Address (if less than 3 years)					State	ZIP
Employer		Occupation		No. of years employed	Spouse's name:	
INSURANCE INFORMATION						
Primary Insurance (Please give your insurance card to the receptionist.)						
Insured's name		Insured's Social Security No.		Insured's Date of Birth	Insurance Company	
		- -		/ /		
Insurance Company Address					State	ZIP
Insurance Company Phone		Insured's Employer		Insured's I.D. # (from card)		Group No.
() -						

Secondary Insurance(Please give your insurance card to the receptionist.)			
Insured's name		Insured's Social Security No.	Insured's Date of Birth
		- -	/ /
Insurance Company Address			State
			ZIP
Insurance Company Phone		Insured's Employer	Insured's I.D. # (from card)
() -			Group No.
MEDICAL HISTORY			
Physician Name		Phone	Dentist Name
		() -	() -
Are you currently under any medical treatment?		<input type="checkbox"/> NO <input type="checkbox"/> YES	Other illness, condition, surgery or problem not listed?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have pain, clicking, and/or popping noises in the jaw?		<input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, please list:
Are you aware of either clenching or grinding of teeth?		<input type="checkbox"/> NO <input type="checkbox"/> YES	Do you bleed easily?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have frequent headaches?		<input type="checkbox"/> NO <input type="checkbox"/> YES	Is there a tendency to faint or become dizzy?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
How often?			Do you have allergies? (Latex , sulphur, penicillin, novocaine, nickel, etc.)
			<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have ear problems? (Aches, ringing, dizziness, fullness)		<input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, please list:
Do you have difficulty breathing through the nose?		<input type="checkbox"/> NO <input type="checkbox"/> YES	Are you currently taking any medication?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?		<input type="checkbox"/> NO <input type="checkbox"/> YES	If Yes, please list:
Have you had your tonsils and / or adenoids removed?		<input type="checkbox"/> NO <input type="checkbox"/> YES	Have you ever taken any weight loss medication (e.g. PhenFen)?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have speech problems, or are you in speech therapy?		<input type="checkbox"/> NO <input type="checkbox"/> YES	Have you ever taken i.v. Bisphosphonates or Oral Bisphosphonates (e.g. Boniva)?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have sleep apnea?		<input type="checkbox"/> NO <input type="checkbox"/> YES	Do you have a heart murmur?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
Has there been any history of:			Do you pre-medicate?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
Joint swelling	<input type="checkbox"/> NO <input type="checkbox"/> YES	Aids	<input type="checkbox"/> NO <input type="checkbox"/> YES
Asthma	<input type="checkbox"/> NO <input type="checkbox"/> YES	Liver Condition	<input type="checkbox"/> NO <input type="checkbox"/> YES
TB	<input type="checkbox"/> NO <input type="checkbox"/> YES	Epilepsy	<input type="checkbox"/> NO <input type="checkbox"/> YES
Kidney	<input type="checkbox"/> NO <input type="checkbox"/> YES	Rheumatic fever	<input type="checkbox"/> NO <input type="checkbox"/> YES
			Are you pregnant?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
			Do you smoke or chew tobacco?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
			Have there been any injuries to the teeth?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
			Were any teeth removed by extractions?
			<input type="checkbox"/> NO <input type="checkbox"/> YES
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address)		Relationship to patient	Home Phone
			() -
			() -
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Iris Erdell. I understand that I am financially responsible for any balance. I also authorize Dr. Iris Erdell or insurance company to release any information required to process my claims.I understand that a credit report may be obtained prior to accepting a payment plan.			
Patient/Guardian signature			Date
Reviewed by			Date
Reviewed by			Date
Reviewed by			Date

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