Patient Medical History

(Please print)

Date________________

Patient____

Last Name First Name Initial (Must match insurance)

Home Phone__________________ Work Phone___________________ Cell_____________________

Street Address____

City State Zip

Sex: ____M _____F Date of Birth ____/____/_____ Social Security #______________________

How did you find out about us? ____

Is there someone we can thank for referring you? ____

In case of emergency, who should be notified? ____________________ Phone__________________

Physician's Name__________________________ Date of Last Physical_______________________

Have you ever had any of the following? (check all that apply)

____Heart Problems	____Epileps y	____Special Diet
____High Blood Pressure	____Headaches	____Swollen Neck Glands
____Low Blood Pressure	____Hepatitis, Jaundice or Liver Disease	____Rheumatic Fever
____Circulatory Problems	____Cancer	____Sinus Problems
____Nervous Problems	____Psychiatric Care	____A.I.D.S. or Immunosuppressive Disorders
____Radiation Treatment	____Chronic Diarrhea	____Stroke
____Artificial Heart Valves or Joints	____Allergies to Anesthetics	____Ulcer
____Recent Weight Loss	____Allergies to Medicine or Drugs	____Venereal Disease
____Back Problems	____General Allergies	____Chemical Dependency
____Diabetes	____Blood Disease	____Hemophilia
____Respiratory Disease	____Arthritis	

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 taking any medication at this time?______If so, what?_______________________________

Are you under the care of a physician?______For what conditions?___________________________

Do you currently have well water? ____Yes ____No

If patient is a child, what is his/her weight?_________________

(woman) Do you suspect that you are pregnant? ____Yes ____No Are you Nursing?__________

Is there anything else we should know about your medical history?___________________________

Insurance Information

Dental Insurance Company___________________________________ Group #_________________

Subscriber's Name_________________________Subscriber's Social Security # _________________

Street Address____

Work #_____________________Home #_____________________Cell #_______________________

Relationship to patient_______________________________Subscriber's Date of Birth ____/___/___

Other family members under plan____

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Subscriber's Employer _______________________Employer Address_________________________

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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

Patient's Signature_________________________ Doctor's Signature________________________