Amini & Associates

General Reconstructive Dentistry
Dorsey Hall Professional Park
5016 Dorsey Hall Drive, Suite 103
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(410) 740 – 1400

Frederick Dental Solutions
Springridge Professional Center
9099 Ridgefield Drive, Suite 206
Frederick, MD 21701
(301) 663 - 7733

New Patient Medical History

(Please print)

Today's Date: _____

Patient:_____
Last Name **First Name** **Middle Initial** **(Must match insurance)**

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

Address:_____
Street **City** **State** **Zip Code**

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Preferred method of contact: ***(Circle one)*** **Home / Email / Text**

In case of emergency, who should be notified?

_____ **Phone**_____

How did you find out about us? _____

Is there someone we can thank for referring you? _____

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

____A.I.D.S. / HIV
____Arthritis
____Cancer / Chemotherapy
____Depression / Anxiety
____Frequent Headaches
____Hepatitis / Liver Disease
____Low Blood Pressure
____Radiation Treatment
____Rheumatic Fever
____Special Diet
____Tobacco Use (E-Cigarettes, Chew, Smoking)
____Alzheimer's
____Asthma
____Chemical Dependency
____Diabetes
____Heart Problems
____High Blood Pressure
____Osteoporosis or Osteopenia
____Recent Weight Loss
____Seasonal Allergies
____Stroke
____Artificial Heart Valves or Joints
____Back or Neck Problems
____COVID-19
____Epilepsy or Seizures
____Hemophilia
____Immunosuppressive Disorders
____Psychiatric Care
____Respiratory Disease
____Sinus Problems
____Thyroid: hypo / hyper

____ Other: _____

_____

_____

New Patient Medical History

Do you have any drug allergies or have you ever had an adverse reaction to any of the following:
____ Amoxicillin ____ Anesthetics ____ Codeine ____ Latex ____ Penicillin

Other:_____

Have you ever responded adversely to medical or dental treatment? ___ Yes ____ No

Are you taking any medication at this time? ___ Yes ____ No

List Medications: _____

_____

_____

Are you taking any calcium supplements? ____Yes ____No

Are you under the care of a physician? ____Yes ____No

For what conditions? _____

Do you currently have well water? ____Yes ____No

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

***(Woman)* Are you currently taking a birth control bill? ____Yes ____No**

Do you suspect that you are pregnant? ____Yes ____No Are you Nursing?_____

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

_____

_____

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

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance for benefits for which I am entitled.

_____ _____
Patient Signature **Date**

_____ _____
Doctor Signature **Date**