Patient Medical History

(Please print)

Date_____

Patient_____

Last Name First Name Initial (Must match insurance)

PHONE: Home _____ Work _____ Cell_____

Email address: _____ CIRCLE PREFERED CONTACT: Text/Email/Call

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

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_____

_____

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

Signature and date _____ Doctor's Signature _____