PATIENT MEDICAL HISTORY

Patient Name: | **Today's Date:**

Mailing Address:

City: | **State:** | **Zip:**

Home Phone: | **Work Phone:** | **Mobile Phone:**

Patient's Date of Birth: | **Social Security No:** | **Marital Status:**

Emergency Contact: | **Relationship:** | **Emergency Contact Phone No:**

IF YOU HAVE DENTAL INSURANCE

Primary Dental Insurance Company: | **Subscriber Name:** | **Subscriber DOB:**

Group Number: | **Subscriber ID:** ***(If you do not have an ID, please provide subscriber SSN)***

Self Insured or Employer Provided Insurance?: | **Employer Name:**

Primary Care Physician Name: | **Physician Phone Number:**

Pharmacy Name: | **Pharmacy Location:** | **Pharmacy Phone Number:**

Sex:

If female, please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

☐ Height ☐ Weight

Please mark each condition yes or no:

Y	N	Conditions
☐	☐	Abnormal bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies/Hay Fever
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer – Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse

Y	N	Conditions
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A/B/C
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker

Y	N	Conditions
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry/Metals
☐	☐	Latex
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Occupation_____

Place of Employment_____

Who may we thank for referring you?_____

The main reason(s) for today's visit?

Toothache

Broken Tooth

Become Established

Consultation

Other /Emergency _____

Please Check Yes or No

Y **N** I would like to talk to the doctor about my gum disease.

Y **N** I would like to discuss my smile or cosmetic issues with the doctor.

Y **N** I need to know what it takes to fix all my teeth including how much it costs and how much time it would take?

Medical Information

Do you have an artificial joint? **Y** **N**

If so, when were they placed?_____

Do you take **Fosamax** or **Actonel**? **Y** **N**

If so, when did you start?_____

Do you take **Aredia, Zometa** or **Reclast**

for Osteoporosis, Paget's disease, Multiple Myeloma or Metastatic Cancer? **Y** **N**

If so, when did you start?_____

Do you have any of the following **heart problems**?

Artificial (Prosthetic) Heart Valve _____

Previous Infective Endocarditis_____

Damaged Valves in a Transplanted Heart?

Congenital Heart Disease?

_____Unrepaired cyanotic?

_____Repaired within the past 6 months?

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

RECORD OF SERVICES

DATE	TOOTH #	SUR-FACE	SERVICES RENDERED	PROD. NO.	SERVICE CODE	FEE	RECALL DATE