MEDICAL HISTORY

Date_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Business Phone:_____ Cell Phone:_____

E-mail address:_____

Date of Birth: _____ Referred By: _____

PATIENT DENTAL HISTORY:

Previous Dentist:_____
Do your gums bleed while brushing: YES____ NO _____
Are your teeth sensitive to HOT/COLD or SWEETS: YES_____ NO_____
Do you clench or grind your teeth: YES____ NO____
Does your jaw ache when you awaken in the morning: YES____ NO _____
Have you had orthodontic "BRACES" treatment: YES_____ NO _____
Have you had prior periodontal "GUMS" treatment: YES_____ NO _____
Have you had any neck, head, or jaw injuries: YES_____ NO _____

Other dental concerns: _____

DENTAL INSURANCE:

Are you covered by dental insurance: YES____ NO _____
Name of Dental Insurance Carrier: _____
Dental Insurance claim address: _____
Dental Insurance Phone#_____

Subscriber: _____ **Subscriber's date of birth**:_____

Subscriber's ID#:_____ **Group#**_____

Subscriber's Employer: _____

MEDICAL HISTORY:

Are you under the care of a physician: YES___ NO ____
Have you been hospitalized for any surgical procedure or serious illness: YES_____ NO ___
If YES, please explain_____
Have you had a medical exam within the past year: YES_____ NO ____
Are you taking any medications including non-prescription medicine: YES____ NO ____
If YES, what medications are you taking: _____
_____
_____
Do you wear contact lenses: YES_____ NO ____

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING PLEASE CIRCLE :

Aspirin Barbiturates Latex Penicillin or other Antibiotics_____

Sulfa Drugs Sedatives Iodine Other: _____

DO YOU SMOKE OR USE TOBACCO: YES: _____ NO:_____
DO YOU NEED TO PRE-MEDICATE FOR DENTAL PROCEDURES: YES___ NO ____
IF YES, PLEASE EXPLAIN_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PLEASE CIRCLE:

HIGH BLOOD PRESSURE	LOW BLOOD PRESSURE	HEART MURMUR	HEART ATTACK
ANGINA	STROKE	PACEMAKER	HEPATITIS
DIABETES	LIVER DISEASE	KIDNEY DISEASE	ASTHMA
ULCER	RHEUMATIC FEVER	EMPHYSEMA	GLAUCOMA
SEIZURES	FAINTING	EPILEPSY OR CONVULSIONS	
THYROID PROBLEMS	AIDS OR HIV INFECTION	OSTEOPOROSIS	

JOINT REPLACEMENTS_____ CANCER_____ If YES, please specify _____
OTHER: _____
WOMEN ONLY:
Are you taking Birth Control Pills or Hormones: YES_____ NO _____
Are you pregnant: YES_____ NO_____ If YES, # weeks_____ Are you nursing: YES____ NO_____

Authorization and Release:

I certify I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist on dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of Patient or Parent of Minor **Date**