SOUTHINGTON
FAMILY DENTISTRY

Patient's name _____Birthdate_____Email_____

Home phone _____ Work phone _____ Cell Phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____

Emergency Contact Name:_____ Emergency Contact phone:_____

Marital Status:_____ If minor, parents names _____ _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

❑ yes ❑ no - Abnormal bleeding after procedures
❑ yes ❑ no - AIDS or HIV positive
❑ yes ❑ no - Alcoholism
❑ yes ❑ no - Anemia or blood disorders
❑ yes ❑ no - Artificial joint and/or any implants
❑ yes ❑ no - Arthritis
❑ yes ❑ no - Asthma
❑ yes ❑ no - Blood transfusion
❑ yes ❑ no - Cancer or tumor
❑ yes ❑ no - Diabetes
❑ yes ❑ no - Emotional condition
❑ yes ❑ no - Epilepsy, seizures, or fainting spells
❑ yes ❑ no - Heart ailment or angina
❑ yes ❑ no - Heart murmur, mitral valve prolapse, heart defect
❑ yes ❑ no - Hepatitis or other liver disease
❑ yes ❑ no - Herpes or cold sores
❑ yes ❑ no - High or low blood pressure
❑ yes ❑ no - Kidney disease
❑ yes ❑ no - Migraine headaches or frequent headaches
❑ yes ❑ no - Neurologic condition
❑ yes ❑ no - Pacemaker or valve
❑ yes ❑ no - Rheumatic fever or rheumatic heart disease
❑yes ❑ no - Thyroid disease
❑yes ❑ no - Tuberculosis or other lung problems
❑ yes ❑ no - Do you smoke or use chewing tobacco

Are you allergic, or have you reacted adversely to any of the following?

❑ yes ❑ no Antibiotics_____
❑ yes ❑ no Aspirin
❑ yes ❑ no Barbiturates, sedatives, or sleeping pills
❑ yes ❑ no Codeine
❑ yes ❑ no Latex materials
❑ yes ❑ no Local anesthetics ("Novocain")
❑ yes ❑ no Narcotics_____
❑ yes ❑ no Penicillin
❑ yes ❑ no Sulfa drugs
Other:_____

Please list your medications:

❑
❑
❑
❑
❑
❑
❑
❑

Premedication for Dental Appointments:_____

Women:

❑ yes ❑ no May be pregnant- Expected delivery date: _____
❑ yes ❑ no Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

INSURANCE INFORMATION: ***ONLY*** complete if you are a ***new patient*** or a continuing patient with ***new insurance***

No Dental Ins_____ Dental Ins. Name: _____
Policy Holder's Name: _____Birthdate: _____/____/____
Employer: _____
Insurance Group #:_____ Insurance ID #:_____
Secondary Dental Insurance: _____ Policy Holder's Name: _____
Birthdate: _____/____/____ Employer: _____

Insurance Group #:_____ Insurance ID #:_____

Signature of patient (or parent) _____ ___ **Date** _____