Patient's name ______________________________________Birthdate________Email____________________________________

Home phone _______________________ Work phone _______________________ Cell Phone _______________________

Mailing address _______________________________________ City _______________________State _______ Zip _________

Employer ___________________________________ SS#:______________________________

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 non-dental 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 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:____Date of last physical____________

Please list any disease, condition, surgeries, 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 #:___________

If applicable - Secondary Dental Insurance: __________________ Policy Holder's Name: _________________________________

Birthdate: _____/____/____ Employer: ____

Insurance Group #: _________ Insurance ID #:___________

SIGNATURE OF PATIENT (OR PARENT) ____ **DATE** _________________________