



Medical History and Patient Information Form

INSURANCE INFORMATION

Last Name, First Name, Middle I.

Street Address

City, State, ZIP

Date of Birth

Social Security

Sex

Marital Status

Home Phone

Business Phone

Occupation/ Employer

Business Address

Spouse's Name

Business Phone

Person Responsible for this Account

Address

Phone

Insured Person's Full Name

Relationship To Patient

Referral Source

Purpose for this Visit

PRIMARY Insurance

Policy Number _____

Group Plan Number _____

SECONDARY Insurance

Policy Number _____

Group Plan Number _____

Teeth sensitivity? Cold | Hot | Sweets | Pressure (circle)

Do you prefer a local anesthetic for most dental treatments? Y N

Bleeding gums? For how long? _____

Food impaction? Y N

Past or present use of chewing tobacco, cigarettes, pipes or cigars? Y N

How long? _____

Swelling or lumps in the mouth? Y N

Frequent on blisters on lips or mouth? Y N

Pain around ear? Y N

Unusual sounds around ear while eating? Y N

Unpleasant taste? Y N

Mouth breathing? Y N

Gum (periodontal) diseases? Y N

Gum (periodontal) treatment? Y N

Do you use dental floss? Y N

Do you use a water jet device? Y N

Do you use an electric toothbrush? Y N

Do you use fluoride rinse? Y N

Do you bite your fingernails or cheeks? Y N

Do you brush twice a day? Y N

Do you like your smile? Y N

Are you under a physician's care? Y N

For what? _____

Date of last physical exam _____

Are you in good health? _____

Date of last dental exam

Date of last x-rays taken

Physician's name and telephone number?

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Medication you are taking (include reason and dosage)

Please explain hospitalization and/or serious illness

Please explain any injuries to the face, head mouth or teeth

Have you ever had an allergic or unusual reaction to any of the following medications?

Dental Anesthetics	Y	N
Codeine or other narcotics	Y	N
Penicillin	Y	N

Aspirin or Tylenol compounds	Y	N
Barbiturates or tranquilizers	Y	N
Erythromycin	Y	N

Any other drug or medication, please list:

Do you have any of the following:

Artificial heart valve or joints	Y	N
Heart pacemaker	Y	N
Heart trouble	Y	N
Mitral valve prolapse	Y	N
Herpes	Y	N
Hepatitis/jaundice/liver disease	Y	N
Blood transfusions	Y	N
Sexually transmitted disease	Y	N
HIV positive	Y	N
AIDS/Immunosuppressive disorders	Y	N
Cold sores	Y	N
Back problems	Y	N
Women, are you pregnant?	Y	N
Women, are you nursing?	Y	N
Women, are you taking birth control pills?	Y	N
Stomach diseases/ulcer	Y	N
Pulmonary (lung) disease	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N
Sinus Trouble	Y	N
Stroke	Y	N

High blood pressure	Y	N
Low blood pressure	Y	N
Thyroid disease	Y	N
Any blood disease	Y	N
Abnormal bleeding from a cut	Y	N
Latex allergy	Y	N
Arthritis	Y	N
Asthma	Y	N
Anemia	Y	N
Anorexia	Y	N
Diabetes	Y	N
Epilepsy	Y	N
Rheumatic fever	Y	N
Kidney disease	Y	N
Migraine headaches	Y	N
Cyst, growth, tumor, or cancer	Y	N
Glaucoma	Y	N
Alcohol/drug dependency	Y	N

Is there anything else we should know about your medical history?

I acknowledge that the information provided on this Patient Medical History form is complete and correct. I understand that payment is expected when services are rendered. As a courtesy to you, we will submit claims to certain insurance companies. However, any outstanding balance will be your responsibility

Patient Signature: _____

Patient Email: _____

Patient Cell Phone: _____

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