

## Medical History

**Patient Information:**

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Residence Phone # \_\_\_\_\_ Cell# \_\_\_\_\_  
 Work# \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 E-mail address(OPTIONAL) \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Who is responsible for this account?

Have you changed dental insurance? Yes \_\_\_ No \_\_\_ **If YES**, please indicate your new insurance information. **If NO, skip**

Insured Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Subscriber# \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Employer: \_\_\_\_\_ Group# \_\_\_\_\_  
 Insurance Co. Name \_\_\_\_\_ Ins. Phone# \_\_\_\_\_  
 Ins. Address \_\_\_\_\_

**Please list ALL medications, including OTC drugs and supplements that you are currently taking:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Have you ever been hospitalized or had major surgery?**

**Y N** \_\_\_\_\_

**Are you pregnant? Y N**

**ALLERGIES TO MEDICATIONS:**

\_\_\_ Penicillin \_\_\_ Codeine \_\_\_ Aspirin  
 \_\_\_ Sulfa \_\_\_ Latex \_\_\_ Anesthetic  
 \_\_\_ Other: \_\_\_\_\_

**Do you have, or have you had, any of the following? Please check all that apply.**

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shingles
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> HPV

**Do you have any conditions not listed above?** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Furthermore, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_