MEDICAL HISTORY FORM

Welcome to our Dental Office. In order to provide you the best care possible, we would appreciate you answering the following questions: Who referred you to the office? ____________

Name: ____________ Emergency Contact: ____________ Phone: ____________

Home Phone: ____________ Bus Phone: ____________ Cell Phone: ____________

Home Address: ____________

Sex: M / F SSN: ____________ DOB: ___ / ___ / _____ Marital Status: S / M / D / W

Employer: ____________ Employer Address: ____________

Spouse Name: ____________ Spouse Phone: ____________ Spouse Cell: ____________

Do you have Dental Insurance? ___ Yes ___ No If yes, Company Name: ____________

Insurance Co. Address: ____________ Ins. Co. Phone: ____________

Ins. Group #: ____________ Member ID: ____________ (if you have access provide copy of plan)

Insured's Name: ____________ Insured's DOB: ___/___/_____ Insured's SSN: ____________

Do you have Secondary Dental Insurance? __ Yes __ No If yes, Company Name: ____________

2nd Ins. Co. Address: ____________ 2nd Ins. Co. Phone: ____________

2nd Ins. Group #: ____________ Member ID: ____________ (if you have access provide copy of plan)

Insured's Name: ____________ Insured's DOB: ___/___/_____ Insured's SSN: ____________

Official Financial and Insurance Policies:

Please pay estimated Co-Payments and deductibles at the date of treatment.
Please pay all remaining balances in 90 days unless a payment plan is completed.
Patients are responsible for all charges on remaining balance after completed insurance payments.
Checks returned for insufficient funds will be assessed a $40.00 fee.
Accounts sent to collection agency will have collection fee added to balance.
After 60 days, all accounts that have all applicable insurance payments completed and no further payments or a payment plan set up, a $40.00 re-billing fee may be assessed.

Patient/Guardian Signature ____________ Date: ___/___/_____

Please circle yes or no to the following questions. Please specify and explain any yes responses.

1. Have you had any general health problems or surgeries? .... Y / N
   If yes, please specify ____________
2. Have you been under the care of a physician during the last 2 years? .... Y / N
3. Name and phone number of Physician(s) ____________
   Date of visit: ___/___/_____ Date of last Physical: ___/___/_____ Reason for visit: ____________
4. Are you taking any medications, drugs, over the counter supplements, or marijuana? .... Y / N
   If yes, please specify ____________
5. Are you presently taking or have taken medications in the past for?
   Anemia, Bleeding Disorders, Blood Thinners, Blood Clots .... Y / N
   Abnormal Tumors, Growths, Cancer, Bone Disorders, Osteoporosis .... Y / N
   Total Joint Replacement, Cardiac Transplant or Artificial Heart Valves .... Y / N
   Long Term / Deep Radiation, Long Term Cortisone Therapy .... Y / N
   Any Connective Tissue, Auto Immune, Chronic Fatigue Disorders .... Y / N

Please circle yes or no to the following questions. Please specify and explain any yes responses.

6. Women:
   - Are you pregnant or nursing? .... Y / N
   - Are you taking birth control? .... Y / N
7. Have you been diagnosed with or treated for a sensory or traumatic (PTSD) condition? .... Y / N
8. Are you allergic to:
   - Local Anesthetics (____________) .... Y / N
   - Penicillin .... Y / N
   - Other Antibiotics (____________) .... Y / N
   - Codeine or other Narcotics (____________) .... Y / N
   - Aspirin .... Y / N
   - Iodine .... Y / N
   - Latex or Rubber .... Y / N
   - Metal or Metal Alloys .... Y / N
   - Other .... Y / N
9. Do you have a recreational or prescription drug addiction? .... Y / N
10. Do you have or have you had any of the following conditions:
   - Damaged Heart Valves, Artificial Valves .... Y / N
   - Allergy, Asthma, Hay Fever, COPD .... Y / N
   - Sudden Weight Loss / Weight Gain, Diabetes .... Y / N
   - Arthritis, Swollen Joints, Artificial Joints .... Y / N
   - Thyroid, Metabolism, Dietary Concerns .... Y / N
   - Seizures, Epilepsy or Neurological Concerns .... Y / N
   - High Blood Pressure, Stroke .... Y / N
   - Cardiac Pacemaker, Irregular Heartbeat .... Y / N
   - Sinus, Snoring, Breathing Issues .... Y / N
   - Immune Disorders, AIDS, HIV .... Y / N
   - Cancer, Chemotherapy, Radiation .... Y / N
   - Persistent Cough, Colds, Tuberculosis .... Y / N
   - Liver, Kidney, Stomach Disease .... Y / N
   - Sexually Transmitted Disease .... Y / N
11. Dental Health:
   - What is your chief dental concern? ____________
   - When was your last dental visit? ___/___/_____ What was it for? ____________
   - Have you been advised of mouth conditions in the past? (gum disease, cavities, infections)
   - Explain ____________
   - If you are new to our office, please explain reasons for change and how you heard about us: ____________

Dr. ________
Date ________

I certify that I have read and understand the above information and the questions have been accurately answered. I authorize the dentist to release any information necessary to other health practitioners providing care to myself and to release information necessary to my insurance company or third party payers. I assume responsibility for any errors or omissions that I have made in the completion of this form that affects my dental treatment.

Patient/Guardian Signature ____________________ Date: ___/___/_____