

Date _____ (PLEASE PRINT) Home Phone _____

Cell Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Employer / School _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse / Parent Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

- | | | |
|------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia |

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? Yes No

For what conditions? _____

Are you interested in bleaching your teeth? Yes No

(Women) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No

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

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

NOTE: Patient is responsible for full fee regardless of what the insurance pays. A 1.5% monthly charge plus all collection fees if necessary for all accounts 60 days past due.

Date _____ Signature _____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Date

Signature