NEW PATIENT MEDICAL HISTORY FORM

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely so we can best care for you.

About You

Today's Date:_____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called:_____ ☐ Male ☐ Female

Birthdate:____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐Single ☐Married ☐Partnered ☐Divorced/Separated ☐Widowed

Hm #: (____)_____ Cell #: (____)_____

Wk #: (____)_____ Ext: ____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

Insurance

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #:(____) _____

Group # (Plan, Local or Policy #):

Insured's Name:_____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #:(____) _____

Group # (Plan, Local or Policy #):

Insured's Name:_____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Spouse Information

His/Her Name:_____

Employer: _____

Birthdate:____/____/____ Cell Phone: _____

If insurance coverage is through spouse, please provide their SS #: _____

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Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, 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. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Please answer the following questions to the best of your ability.

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? YES NO
If yes, Doctor Name & Explain:

_____

Have you ever been hospitalized or had a major operation? YES NO

Have you ever had a serious head or neck injury? YES NO

Are you taking any medications, pills or drugs? YES NO
If yes:_____

Do you take or have you ever taken Phen-Fen or Redux? YES NO

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? YES NO

Are you on a special diet? YES NO

Do you use smoke or use tobacco products? YES NO

Do you use any controlled substances? YES NO

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #: _____
Are you nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

Aspirin	YES	NO	Latex	YES	NO
Penicillin	YES	NO	Sulfa Drugs	YES	NO
Codeine	YES	NO	Dental/Local Anesthetics	YES	NO
Acrylic	YES	NO	Erythromycin	YES	NO
Metal	YES	NO	Other	YES	NO

Please list any other drug/materials that you are allergic to:

_____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No
Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No
Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No
Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft
Have you ever had gum treatment? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No
Are your teeth sensitive to heat, cold, or anything else? _____
Do you have any loose teeth? ☐ Yes ☐ No
Do you still have wisdom teeth? ☐ Yes ☐ No
Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No
Have you had any metal rods, pins or implants? ☐ Yes ☐ No
Have you ever been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____
Signature Date

Please circle ALL of the below if you have had or have the following:

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

Check this box if you have NOT had any of the above: ☐

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.
Dentist Initials: **Date:**

_____

Comments:

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.