Patient Information

Name _____ Home Phone _____
First MI Last

Address_____ City_____ State_____ Zip_____

DOB _____ Social Security #_____ (For insurance purposes)

Cell Phone #_____ Work Phone #_____Email_____

Medical History

Physician _____ Date of last Visit _____

Yes No Is your general health good?

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control? Yes No

Yes No Do you have any allergies to foods, medications, metals, latex, etc?
If so, which ones? _____

Yes No Are you currently under a doctor's care?
What are you currently being treated for? _____

Yes No Have you ever taken Fen Phen or Redux medications?

Yes No Have you ever had any adverse reactions for any dental procedure or medications?

Yes No Have you had any type of surgery in the last 6 months? What type of surgery? _____

List of medications you are presently taking_____

_____

Do you have or have you ever had any of the following?

Yes No AIDS	Yes No Epilepsy	Yes No Pacemaker
Yes No Anemia	Yes No Fainting	Yes No Psychiatric Care
Yes No Arthritis, Rheumatism	Yes No Glaucoma	Yes No Radiation Treatment
Yes No Artificial Heart Valves	Yes No Heart Murmur	Yes No Respiratory Disease
Yes No Artificial Joints	Yes No Hemophilia	Yes No Rheumatic Fever
Yes No Asthma	Yes No Hepatitis	Yes No Scarlet Fever
Yes No Blood Disease	Yes No High Blood Pressure	Yes No Shortness of Breath
Yes No Cancer	Yes No HIV Positive	Yes No Stroke
Yes No Chemical Dependency	Yes No Jaw Pain	Yes No Thyroid Problems
Yes No Chemotherapy	Yes No Kidney Disease	Yes No Tobacco Habit
Yes No Circulatory Problems	Yes No Liver Disease	Yes No Tuberculosis
Yes No Diabetes	Yes No Mitral Valve Prolapse	Yes No Tonsillitis

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records for any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may payless than the actual bill for services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents.

X _____
Signature of Patient (or parent if a minor)

Date _____

Medical Updates

Please review medical history and make any changes necessary. Thank you for your cooperation.

Date _____ Patient Signature _____

Date _____ Patient Signature _____

Date _____ Patient Signature _____

Date _____ Patient Signature _____