Welcome Medical History

(Please complete form in its entirety)

Name:	Male/Female	Today's Date
Date of birth:	Social Security # - -	Occupation/Employer
Single/Married/Divorced/Widowed/ Minor		

Street Address:		Who may we THANK for referring you to our practice?
City:	State:	Zip Code:
Home Telephone:	Cell:	Work:
Email Address:		

Student Status 26>

Full / Part Time	Name of School:

Spouse/Parent/Guardian Information

Spouse/Parent /Guardian Name:			Parent /Guardian (2) Name:		
Address:			Address:		
City	State	Zip	City	DE	Zip
Telephone:			Telephone:		
Date of birth:			Date of birth:		

Insurance Information

Primary Insured Name	Date of Birth:	SSI#
Employer:	Insurance Company Name:	
Insurance Company Telephone#:		Insurance ID#
Group Number:		
Secondary Insured Name	Date of Birth:	SSI#
Employer:	Insurance Company Name:	
Insurance Company Telephone#:		Insurance ID#
Group Number:		

Please allow our staff to make a copy of your identification card and dental insurance card

Turn Over>>

Medical History

Physician Name:	Physician Telephone Number:
Emergency Contact:	Emergency Contact Telephone Number:

List of current medication: ____

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Are you generally in good health?			Yes / No
Do you have any food, medication, metal, latex allergies?			Yes / No
Are you currently under a physicians care? For?			Yes / No
Have you had any surgeries in the last 2 years?			Yes / No
Have you had an orthopedic total joint replacement? (hip, knees, elbow, fingers)			Yes / No
Has a physician or dentist recommended that you take antibiotic prior to dental visits? If yes, what do you take?			Yes / No
Have you ever had any adverse reactions to dental procedures?			Yes / No
Have you ever had any adverse reactions to dental anesthia?			Yes / No
Are you pregnant? Yes/No If yes, what trimester		OBGYN Telephone Number: ( ) -	
Artificial heart valve	Yes / No	Bronchitis	Yes / No
Endocarditis	Yes / No	Emphysema	Yes / No
Congenital heart disease	Yes / No	Sinus trouble	Yes / No
Cardiovascular disease	Yes / No	Cancer/Chemo/Radiation Treatment	Yes / No
Angina	Yes / No	Chest pain upon exertion	Yes / No
Arteriosclerosis	Yes / No	Chronic pain	Yes / No
Congestive heart failure	Yes / No	Diabetes Type I or II (Circle)	Yes / No
Damaged heart valves	Yes / No	Eating disorder	Yes / No
Heart attack	Yes / No	Gastrointestinal disease	Yes / No
Heart murmur	Yes / No	Reflux/Heartburn	Yes / No
Blood Pressure Low / High (Circle one)	Yes / No	Ulcers	Yes / No
Other congenital heart defects	Yes / No	Thyroid Problems	Yes / No
Mitral valve prolapse	Yes / No	Stroke	Yes / No
Pacemaker	Yes / No	Glaucoma	Yes / No
Rheumatic fever	Yes / No	Hepatitis A ,B , C (Please circle) Jaundice or liver disease	Yes / No
Rheumatic heart disease	Yes / No	Epilepsy	Yes / No
Abnormal bleeding	Yes / No	Fainting spells or seizures	Yes / No
Anemia	Yes / No	Neurological disorders (specify)	Yes / No
Blood transfusion If yes, date:	Yes / No	Do you snore?	Yes / No
Hemophilia	Yes / No	Mental health disorder (specify)	Yes / No
AIDS or HIV infection	Yes / No	Recurrent infections (type)	Yes / No
Arthritis	Yes / No	Kidney problems	Yes / No
Autoimmune disease	Yes / No	Osteoporosis	Yes / No
Rheumatoid arthritis	Yes / No	Persistent swollen neck glands	Yes / No
Lupus	Yes / No	Severe headaches/ migraines	Yes / No
Asthma	Yes / No	Do you use tobacco?	Yes / No
Do you Do you have any disease, condition, or problem not listed above that you think we should be aware of? Yes / No			

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 understand SSED has an open door treatment policy for minor child and I understand that I may accompany my minor child into the treatment room or observe from a safe distance. I authorize the dentist/staff to release my 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 pay less then what is actually billed for my services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependants. Note: This information is for official and medically-confidential use only and will not be released to unauthorized persons.

I, ____________________________________, herby grant permission to SSED to discuss diagnosis, treatment options, and financial arrangements with:

____ _______________________ ____ _______________________

Name Relationship to Patient Name
Relationship to Patient

	Date:

compliment you can give us is referrals of your friends and family. To thank you, we will give you on your account to you towards your future dental work.