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For Office Use Only
Premed:
Allergies:
Medical Alert:

Welcome to our Office!

Date: _____

***To whom May We Thank for Referring You? _____**

Patient Information

Name (Last, Firs, MI)			Date of Birth:	
Check Appropriate Box: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed				
Address:	City		State	Zipcode
Home#:	Cell#		Work#	
Email Address:				
How do you prefer to be contacted: Home# ☐ Cell# ☐ Work# ☐ **(Please indicate in what order)**				
Person to Contact in Case of Emergency		Phone#		

Northern Address

Address:	City	State	Zipcode
Phone #:			

Responsible Party

Name of Person Responsible for this Account:		Relationship to Patient:	
Address:	City	State	Zipcode
Home# Cell#	Work#	Email Address:	

Dental Insurance Information

Policy Holder:	Birthdate:
Social Security:	ID#
Name of Employer	
Insurance Company:	Phone #:

Do You Have Secondary Insurance? ☐ Yes or ☐ NO

Patient Dental History

1. Are you having any discomfort at this time?	☐ YES	☐ NO
2. Do you feel nervous about having dental treatment?	☐ YES	☐ NO
3. Have you had any complications with extractions?	☐ YES	☐ NO
4. Are you happy with your smile?	☐ YES	☐ NO

Patient Medical History

Physician:	Office Phone#:
Date of Last Exam?	Date of Last Blood Work?

1. Are you under medical treatment now? ☐ YES or ☐ NO

2. Have you been hospitalized or have had any surgical procedures in the last two years? ☐YES or ☐NO
If YES, please explain:
_____
_____

3. What medications/vitamins/herbal supplements are you currently taking?

Name of Medication	Reason for taking the Medication

4. Are you ALLERGIC or have you reacted adversely to any of the following medications?

Antibiotics
☐Azithromycin (Z-Pak)
☐Erythromycin
☐Penicillin/ Amoxicillin
☐Sulfa
☐Tetracycline/Other _____

Pain Reliever
☐Aspirin
☐Acetaminophen
☐Codeine
☐Percoclan
☐Other _____

Miscellaneous
☐Latex
☐Local Anesthetic-(Novacaine/Xylocaine)
☐Metals (e.g. gold,nicke,l mercury,etc)
☐Other _____

5. Check ANY of the following that you have had or have at the present time.

☐Acid Reflux	☐COPD	☐Hepatitis-A/BIC/ D	☐Pacemaker
☐Allergies (Hay Fever)	☐Diabetes	☐High/ Low Blood Pressure	☐Psychiatric Treatment
☐Alzheimer's/Dementia	☐Dialysis	☐Joint Replacement	☐Radiation Treatment/Therapy
☐Anemia	☐Emphysema	☐Kidney Disease	☐Sexually Transmitted Disease
☐Arthritis	☐Epilepsy/Seizures	☐Liver Disease	☐Sickle Cell Disease
☐Artificial/Repaired Heart Valve	☐Fainting/Dizzy Spells	☐Mental Illness	☐Stroke
☐Asthma	☐Glaucoma	☐Mitra Valve Prolapse	☐Thyroid Disease
☐Auto Immune Disorder/Disease	☐Heart Attack/Chest Pain	☐MRSA/Staph Infection	☐Tuberculosis
☐Chemotherapy	☐Heart Surgery	☐Organ Transplants	☐Ulcers
☐Congenital Heart Defect	☐Hemophilia	☐Osteoporosis	☐Other_

*Have you ever taken bone density medication? ☐ Yes or ☐ No
If Yes, please indicate the name of the drug & when _____

**** NO CHANGE IN MEDICAL HISTORY** INITIAL HERE _____ DATE _____ INITIAL HERE _____ DATE _____**

Authorization and Release

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 Gan be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of 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 u understand that my dental Insurance carrier may pay less than the actual bill for services. I agree, to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date

_____ Signature of Patient (or parent/guardian if minor)

Date	FOR OFFICE USE ONLY	Date	HEALTH HISTORY UPDATE