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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, First, MI)		Date of Birth:	
Check Appropriate Box: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> 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

- Are you having any discomfort at this time? YES NO
- Do you feel nervous about having dental treatment? YES NO
- Have you had any complications with extractions? YES NO
- Are you happy with your smile? YES NO

Patient Medical History

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

- 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, mercury,etc)
 Other _____

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

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