MEDICAL HISTORY

Name_____ Date_____
Last First Middle

Address _____
Number and Street City State Zip

Phone # Primary_____Cell/Home Secondary#_____Cell/Home

Date of Birth _____ SS#_____ ___Sex – M F Marital Status – S M W O

Spouses Name_____ If a child parents name_____

Employer _____ Occupation _____

Employer Phone #_____ Are we able to call you at work – Yes No

Emergency Contact not living with you – Name_____ Phone # _____

If completing this form for another person, what is your relationship?

Name _____ Relationship_____

PLEASE ANSWER EACH QUESTION BELOW – CIRCLE YOUR ANSWERS

1. Physicians name and phone # _____

2. Date of last physical exam _____

3. Have you had any serious illnesses or been in the hospital in the last 2 years? Yes No
   Explain:_____

4. Are you taking any drugs or medications? Yes No
   Please List all drugs or medications_____

_____

_____

5. Are you allergic to penicillin, sulfa, codeine or any other drug or medications ? Yes No

_____

6. (Women) Are you Pregnant? _____ Yes No

7. CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR SUSPECTED

Acid Reflux	Epilepsy	High Blood Pressure	Sinus Trouble
Alzheimer's	Fainting Spells	Joint Replacement	Snoring
Anemia	Frequent Headaches	Latex Allergy	Stroke
Arthritis	GERD	Low Blood Pressure	Thyroid Problems
Asthma	Artificial Heart Valve	Lung Disease	Tobacco Use
Bleeding Problems	Heart Trouble	Milk Allergy	Tuberculosis
COPD	Hepatitis	Psychiatric Treatment	Venereal Disease
Dementia	Hiatal Hernia	Rheumatic Fever	Cancer_____
Diabetes	HIV/AIDS	Seizures	Other_____

8. If you have dental insurance – Policy holder's name _____
   Insurance company name and address _____
   Group Number _____ DOB and SS# or ID# of Policy Holder_____
   Employer Name and Address _____

9. If you have additional dental insurance – Policy holder's name _____
   Insurance company name and address _____
   Group Number _____ DOB and SS# or ID# of Policy Holder _____

_____ _____
Signature of person completing this form Signature of Dentist

Authorization and Release

I certify that the information provided on my health history has been provided as accurately as possible. I authorize the dentist to release any information, including diagnosis and 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, should I have insurance and if they will do so, to pay any insurance benefits directly to the treating dentist. I understand that if I have dental insurance and the carrier pays less than the actual fee for services, that I am responsible for those fees. I agree to be responsible for the payment of all services rendered on behalf of me or my dependents, and also for any charges which may arise from collection of those fees.

_____ _____

Signature of patient or parent if patient is a minor date