PATIENT HEALTH HISTORY

Patient Name: ______________________ Physician's Name: ______________________

Physician's Address: ______________________ Physician's Phone #: ______________________

MEDICAL HISTORY

Your comfort and good dental health are dependent upon an accurate knowledge of your medical well being. Many medical situations can affect or be affected by procedures or drugs used for dentistry. Therefore, please fill out the following carefully. Thank You.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Circle any of the following which you have had or do have now:

Heart trouble	Tuberculosis	Glaucoma
Heart murmur	Hepatitis	Venereal Disease
Rheumatic fever	Stroke	Kidney trouble
High blood pressure	Liver trouble	Lung/breathing trouble
Asthma	Blood disorders	Psychiatric treatment
Fainting spell	Excessive bleeding	Radiation therapy
Ulcers	Epilepsy/seizures	Prosthetic joint(s)
Diabetes	Positive to AIDS Virus	Hiatial hernia

Comments: ______________________

____

Are you allergic to any food, drug or medication? Yes No

If yes, what? ______________________

Are you taking drugs or medication: Yes No

Medication:	Dosage (mg and # per day)	Action:

Are you pregnant? Yes No

If yes, number of months ______________________

Is there any other information about your health we should know? Yes No

____

____

I understand that I am to return to my dentist for permanent restoration of the treated tooth.

Patient (Parent/Guardian) ______________________ ______________________

Signature Date

Complete Reverse Side

PATIENT INFORMATION

PATIENT

DR.
MR.
MRS.
MISS ______________________________

PATIENT | LAST NAME | FIRST NAME | MI. | DATE OF BIRTH

MAILING ADDRESS | STREET | CITY | STATE | ZIP

STREET ADDRESS (IF DIFFERENT) | STREET | CITY | STATE | ZIP

SPOUSE'S NAME | PATIENT'S SOCIAL SECURITY # | HOME PHONE #

PATIENT'S EMPLOYER | EMPLOYER'S ADDRESS | BUSINESS PHONE #

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU | RELATIONSHIP | PHONE #

REFERRED BY | GENERAL DENTIST

INSURANCE

COMPLETE THIS SECTION IF YOU HAVE DENTAL INSURANCE
AND PRESENT INSURANCE FORM TO RECEPTIONIST

	Insurance Company Name	Policyholder (Subscriber)	Policy / Certificate Number and Subscriber Number
1.			
2.			

RESPONSIBLE PARTY

DR.
MR.
MRS.
MISS ______________________________

LAST NAME | FIRST NAME | MI. | RELATIONSHIP TO PATIENT

MAILING ADDRESS | STREET | CITY | STATE | ZIP

HOME PHONE # | BUSINESS PHONE # | OCCUPATION

EMPLOYER | EMPLOYER'S ADDRESS

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services.

Preferred method of payment : ☐ Cash ☐ Check ☐ Credit Card (MasterCard/Visa/American Express)

DATE | SIGNATURE OF PATIENT, PARENT, OR RESPONSIBLE PARTY

COMPLETE REVERSE SIDE