PATIENT MEDICAL HISTORY

Patient's Name: ______________________________ Birthday: ____________________
Address: ____
City: _________________________ State: _________________ Zip: ____________
Email: ________________________ Marital Status: ________ SSN: _____-_____-_____
Home PH: ________________ Work PH: ________________ CELL: ________________

Dental Insurance Information: **(If this information is missing/incomplete we may not be able to bill)**
Primary Dental Policy Holder: ______________________ Date of birth: ______________
Ins. Co.___________________ PH.________________ Member ID: ______________
Group #: ___________ SSN ______________ Employer ________________________
Secondary Dental Policy Holder: __________________ Ins. Co. ___________________
PH: _________________ Member ID: ________________ Group # _______________
Spouse_______________________ Employer___________________________

Medical Information:
Physician Name: _______________________ Physician Phone: ____________________
Pharmacy: ____________________________ Pharmacy Phone: ____________________
Sex: Male [] Female []

If female, please answer by circling the following:
Y N Are you taking birth control pills?
Y N Are you pregnant? If yes # of wks: _____
Y N Are you nursing?

Please answer the following:
Y [] N [] Do you smoke or use tobacco?
Y N Do you have a history of substance abuse?
Height: _______ Weight: ________

Y N Have you ever had a sleep test or CPAP?

CONDITIONS: PLEASE CIRCLE ALL THAT APPLY TO YOU

Yellow Jaundice
Venereal Disease
Ulcers
Tuberculosis
Thyroid Problems
Stroke
Sinus Problems
Sickle Cell Disease
Shingles
Seizers
Rheumatic Fever
Radiation Therapy
Psychiatric Problems
Pace Maker
Mitral Valve Prolepses
Liver Disease
Kidney Problems
HIV-AIDS
High Blood Pressure
Hepatitis A B or C (circle)
Hemophilia

Heart Surgery
Heart Attack
Glaucoma
Frequent Headaches
Fever Blisters
Fainting Spells
Epilepsy
Emphysema
Sleep Apnea
Difficulty Breathing
Diabetes
Cosmetic Surgery
Congenital Heart Defect
Colitis
Cancer-Chemotherapy
Blood Transfusion
Asthma
Artificial Heart Valve
Artificial Bones
Arthritis
Angina Pectoris

Anemia
Allergies
Pain in Jaw Joints
Abnormal bleeding
Hay Fever
Low Blood Pressure
Alcohol Abuse
Drug Abuse

ALLERGIES
Aspirin
Codeine
Dental Anesthetics
Erythromycin
Jewelry
Latex
Metals
Penicillin
Tetracycline
Other

OVER →