MEDICAL HISTORY / FINANCIAL FORM

Patient Information: *Nickname:*_____ *Employer:*_____ *Occupation:*_____

First Name _____ *Middle* _____ *Last Name* _____

Address _____ *City* _____ *State* _____ *Zip Code* _____

Telephone: Home (____) _____ - _____ *Work* (____) _____ - _____ *Cell* (____) _____ - _____

S.S. # _____ - _____ - _____ *Date of Birth:* _____ *Age:* _____ ❑*Male* ❑*Female*

Marital Status: ❑Single ❑Married ❑Widow **Email:**_____

Account Information:→ ***For the responsible party of a patient that is under age 18 or an incompetent patient age 18 or older.***

Print Full Name _____ *Date of Birth:* _____ ❑Male ❑Female

Address _____ *City* _____ *State* _____ *Zip Code* _____

Telephone: Home (____) _____ - _____ *Work* (____) _____ - _____ *Cell* (____) _____ - _____

S.S. # _____ - _____ - _____ *Employer:* _____ *Occupation:* _____

Marital Status: ❑*Single* ❑*Married* ❑*Widow* Relation to Patient: ❑*Self* ❑*Spouse* ❑*Parent* ❑*Guardian* ❑*Facility*

Pharmacy: ❑CVS ❑Walgreens **Other:** _____ **Phone:** (____) _____ - _____

Address _____ *City* _____ *State* _____ *Zip Code* _____

DENTAL HISTORY: Purpose of Today's Visit: _____ Referred By: _____

(Estimates Only) Last Dental Visit: _____ How often do you Brush your Teeth: _____

Last Cleaning: _____ Last Bite-Wing (CHECK-UP) X-rays:_____ Last full set of x-rays (FMX) or Panoramic Film:_____

PRIMARY CARE PHYSICIAN (Medical Doctor): _____ Telephone: (____) _____ - _____

Last visit: _____ Name and Date of Last Prescription for **Pain**: _____

Pre-Medication and instructions:_____

MEDICATIONS: (current list)

FEMALE History: ❑**Pregnant** (____ Months) ❑Trying to get Pregnant ❑Nursing ❑Taking Oral Contraception's ❑Reached Menopause

ALLERGENS: ❑None ❑Latex Rubber ❑Lidocaine ❑Acrylic ❑Metal ❑Sulfa Drugs ❑Penicillin ❑Aspirin ❑Motrin ❑Tylenol ❑Amoxicillin ❑Vinyl ❑Mepivacaine ❑Epinephrine ❑Percocet ❑Vicodin ❑Ibuprophine ❑Acetaminophen

Other:

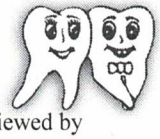
YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	Smoke or Chew Tobacco	❑	❑	Stroke	❑	❑	Artificial Joint	❑	❑	Sickle Cell Disease	❑	❑	Nervous of Dentist
❑	❑	History of Drug Abuse	❑	❑	HIV / AIDS	❑	❑	Wheelchair Patient	❑	❑	Thyroid Disease	❑	❑	Nervous Disorder
❑	❑	_____cancer	❑	❑	Venereal Disease	❑	❑	Hearing Problems	❑	❑	Parkinson's Disease	❑	❑	Diabetes
❑	❑	Angina / Chest Pain	❑	❑	Genital Herpes	❑	❑	Deaf / Hearing Impaired	❑	❑	Head Injury	❑	❑	Bruise Easily
❑	❑	Heart Attack / Failure	❑	❑	Hepatic Infection	❑	❑	Blind / Sight Impaired	❑	❑	Hives or Rash	❑	❑	Arthritis
❑	❑	Heart Disease	❑	❑	Hepatitis B	❑	❑	Earache	❑	❑	Skin Sores / Blisters	❑	❑	TMJ / Jaw Pain
❑	❑	Heart Murmur	❑	❑	Hepatitis C	❑	❑	Headaches	❑	❑	Tumors or Growths	❑	❑	Epilepsy (seizures)
❑	❑	Heart Surgery	❑	❑	High Blood Pressure	❑	❑	Shortness of Breath	❑	❑	Cortisone Medicine	❑	❑	Risky Behavior
❑	❑	Heart Valve Problems	❑	❑	Low Blood Pressure	❑	❑	Respiratory Disease	❑	❑	Thoughts of Suicide	❑	❑	Jaundice
❑	❑	Pulmonary Embolism	❑	❑	Parathyroid Disease	❑	❑	Lung Disease	❑	❑	Rheumatism	❑	❑	Colitis
❑	❑	Bleeding Problems	❑	❑	Portal Hypertension	❑	❑	Emphysema	❑	❑	Swelling of Limbs	❑	❑	Paranoia
❑	❑	Excessive Bleeding	❑	❑	Rectal Bleeding	❑	❑	Breathing Problems	❑	❑	Crohn's Disease	❑	❑	Gout
❑	❑	Bruxism (teeth Grinding)	❑	❑	Fainting / Dizziness	❑	❑	Asthma	❑	❑	Anemia	❑	❑	Depression
❑	❑	Positive Chest X-ray	❑	❑	Digestive Tract Ulcer	❑	❑	Tuberculosis	❑	❑	Kidney Problems	❑	❑	Mood Swings
❑	❑	Oxygen Tank for Breathing	❑	❑	Hallucinations	❑	❑	Rheumatic Fever	❑	❑	Cataracts	❑	❑	Liver Disease
❑	❑	Recent Blood Transfusion	❑	❑	Leukemia	❑	❑	Alzheimer's Disease	❑	❑	Patient on Dialysis	❑	❑	Psychiatric Care
❑	❑	Stomach or Peptic Ulcer	❑	❑	Cerebral Palsy	❑	❑	Convulsions	❑	❑	Stomach Disease	❑	❑	Violent Behavior
❑	❑	Painful Urination	❑	❑	Blood in Urine	❑	❑	Blood in Stool	❑	❑	Constipation	❑	❑	Heartburn

Additional Health Information?

*By signing below, I agree that I am the legally responsible party of the patient, **I have read and understand the privacy practices related to this office (HIPPA Act)**, information on this form is current and correct to the best of my knowledge, and I will update above with this office before treatment is performed. Upon request, a new Medical History form will be filled out every 2-3 years.*

_____ _____ _____

Signature of Responsible Party **Print Full Name of Responsible Party** **Date**



Medical History Reviewed by Dr: _____ Dr. Signature: _____ Date: _____

Medical Updates: Date Exceptions None Patient's initial BP Reviewed by

_____ _____ _____ _____ _____ _____