MEDICAL HISTORY

Patient Name: _____ Today's Date: ____/____/_____
Last, First MI (Preferred Name)

Gender: ☐ Male ☐ Female Height: _____ Weight: _____ Birth Date: ____/____/_____

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician:_____ Phone: _____

Have you been recently hospitalized? If Yes when and why?_____

Date of Last Dental Visit: _____ Reason for Today's Visit: _____

Have you ever had any of the following? If "yes" please check those that apply:

☐ AIDS
☐ Angina (Chest Pain)
☐ Anemia
☐ Arthritis
☐ Artificial Joint(s)
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy, Seizures
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Glaucoma
☐ Hay Fever, Allergies
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Artificial Heart Valve
☐ Hepatitis A, B, or C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Pregnancy
Due date:_____
☐ Venereal Disease
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tobacco Use
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers

Are you allergic to any of the following…
☐ Codeine ☐ Anesthetics
☐ Penicillin ☐ Latex
☐ Aspirin ☐ Metal
☐ Other

Are you taking or scheduled to take either alendronate (Fosamax®),Aredia®, Zometa®) or risedronate (Actonel®), for osteoporosis or Paget's disease?

☐ Yes ☐ No

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you unhappy with the appearance of your teeth? If yes, why? _____
- Are you currently experiencing dental pain or discomfort? ☐ Yes ☐ No
- Do you wear dentures or partials? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had periodontal (gum) treatment? ☐ Yes ☐ No • Do your gums bleed when you brush or floss? ☐ Yes ☐ No
  If yes, when: _____
- Do you have any clicking or popping of your jaw? ☐ Yes ☐ No • Do you grind your teeth? ☐ Yes ☐ No
- Have you had any serious trauma or injury to your head or neck? ☐ Yes ☐ No
- List any medication(s) prescription or over the counter that you are currently taking:

1. _____ 3. _____
2. _____ 4. _____

Vitals: BP_____ HR_____ Date: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is a change in my health status, I will inform the doctor at the next appointment without fail.

_____ Date _____Relationship to Patient _____
Signature of Patient,Parent or Guardian and/or Responsible Party

Patient Registration

Name: _____
Last, First MI (Preferred Name)

Social Security #: _____ Marital Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Phone (Home): _____ Cell: _____ email: _____

Address: _____
Street Apt # City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Insurance Website ☐ Google ☐ Drive by ☐Other

☐ Another patient or office/ If so, name of person or office referring you to our practice: _____

Insurance Information

Name of Subscriber: _____ Subscriber's Birth Date: _____
Last, First MI

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company_____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Employer Name: _____ Employer Phone: _____

Employer Address: _____
Street City State Zip Code

Secondary Insurance

Name of Subscriber: _____ Subscriber's Birth Date: _____
Last, First MI

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company_____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Employer Name: _____ Employer Phone: _____

Employer Address: _____
Street City State Zip Code

Consent for Services

I certify that I am covered by the above stated insurance company and I assign directly to Alem Family Dental all insurance benefits otherwise payable to me. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I understand that I am responsible for payment of services rendered and also responsible for paying any portion that my insurance does not cover (copay) at the time of service.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian/responsible party