



MEDICAL HISTORY

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

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:

- Medical conditions checklist including AIDS, Angina, Anemia, Arthritis, Artificial Joint(s), Asthma, Blood Disease, Cancer, Diabetes, Dizziness, Epilepsy, 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, 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

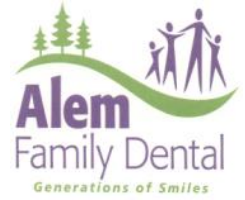
List any medication(s) prescription or over the counter that you are currently taking:

- 1. 2. 3. 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.

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



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.

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