Dental Offices, LLP
Medical History

Please complete front and back of form

Date: __________ Patient Name: ______________________________ Date of Birth: __________

- ☐ Yes ☐ No Is your general health good?
- ☐ Yes ☐ No Have you been hospitalized or had a serious illness in the last three years?
  If YES, why? ______________________________
- ☐ Yes ☐ No Are you being treated by a physician now? For what? __________

Date of last medical exam? __________ Current physician: __________

HAVE YOU EXPERIENCED:

- ☐ Yes ☐ No Chest pain (angina)
- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No Fainting spells of seizures
- ☐ Yes ☐ No Bleeding problems, bruising easily
- ☐ Yes ☐ No TMJ (jaw joint) problems
- ☐ Yes ☐ No Sinus problem
- ☐ Yes ☐ No Dry mouth

DO YOU HAVE OR HAVE YOU HAD:

- ☐ Yes ☐ No Heart disease/heart attack/heart defects
- ☐ Yes ☐ No Heart murmurs/mitral prolapse
- ☐ Yes ☐ No Rheumatic fever
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No High blood pressure
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Stomach problems/ulcers
- ☐ Yes ☐ No Asthma/TB/emphysema/other lung disease
- ☐ Yes ☐ No Tumors/cancer
- ☐ Yes ☐ No Treatment with steroids or cortisone
- ☐ Yes ☐ No Immune disorders
- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Kidney/bladder disease
- ☐ Yes ☐ No Thyroid/adrenal disease
- ☐ Yes ☐ No Hepatitis/Other liver disease
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Allergy to penicillin
- ☐ Yes ☐ No Allergy to latex
- ☐ Yes ☐ No Allergy to medications
  Please list: __________

DO YOU HAVE OR HAVE YOU HAD:

- ☐ Yes ☐ No Radiation treatments
- ☐ Yes ☐ No Chemotherapy
- ☐ Yes ☐ No Prosthetic heart valve
- ☐ Yes ☐ No Artificial joint
- ☐ Yes ☐ No Blood transfusions
- ☐ Yes ☐ No Pacemaker
- ☐ Yes ☐ No Contact lenses
- ☐ Yes ☐ No Head or neck/oral cancer

ARE YOU TAKING:

- ☐ Yes ☐ No Recreational drugs
- ☐ Yes ☐ No Prescription drugs or OTC medicines
- ☐ Yes ☐ No Aspirin
- ☐ Yes ☐ No Tobacco in any form Amt? __________
- ☐ Yes ☐ No Alcohol: Amount? __________
- ☐ Yes ☐ No Herbal supplements
- ☐ Yes ☐ No Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)

PLEASE LIST CURRENT MEDICATIONS: ______________________________

WOMEN ONLY:

- ☐ Yes ☐ No Are you or could you be pregnant/nursing?
- ☐ Yes ☐ No Taking birth control pills?

ALL PATIENTS:

- ☐ Yes ☐ No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If Yes, please explain: ______________________________

Please list all past surgical procedures: ______________________________

Prior hospitalizations: ______________________________

To the best of my knowledge, I have answered every question completely and accurately.
I will inform my dentist of any change in my health and/or medication(s).

Patient signature __________ Staff __________ Date __________

Height __________ Weight __________

OVER →

Dental Offices, LLP

PATIENT INFORMATION RECORD

Patient name ____ Date of birth ____________

Social Security # ___________________________ Gender M F

Home street address ____

City/State/Zipcode ____

Home phone _________________ Cell phone _________________________ Work phone ______________________

Email address ____

INSURANCE

For your convenience, if you have dental insurance we will do everything possible to assist you in obtaining maximum benefits, including estimating the coverage you have available, preparing pre-authorizations and submitting charges to your insurance company to expedite your proper reimbursement. Please understand that while our general dentists do not contract with your insurance company, we will gladly file dental insurance claims as a courtesy to our patients, if provided with the necessary information to do so. Our knowledgeable staff is happy to assist you with all insurance questions.

INSURANCE INFORMATION (PLEASE COMPLETE IN FULL AND PROVIDE ID CARDS)

Primary dental insurance _____________________________________ ID# ________________ Group# ______________

Subscriber/policy holder name ________________________________ Employer name _________________________________

Subscriber date of birth _________________

Secondary dental insurance __________________________________ ID# ________________ Group# ________________

Subscriber/policy holder name ________________________________ Employer name _________________________________

Subscriber date of birth ________________

MEDICARE ADVANTAGE PLAN WITH DENTAL COVERAGE? YES NO

(PLEASE COMPLETE IN FULL AND PROVIDE ID CARDS)

MEDICARE plan ____ ID# ________________ Group# ______________________

Subscriber/policy holder name _________________________________

Subscriber date of birth ___________________

For staff use only

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