DENTAL ASSOCIATES, P.A.

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Medical History

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ ADD/ADHD/Lrng Disabi	☐ Acid Reflux/GERD	☐ Allergy- Aspirin	☐ Allergy- Clindamycin
☐ Allergy- Codeine	☐ Allergy- Latex	☐ Allergy- NSAIDs	☐ Allergy- Penicillin
☐ Allergy- Sulfa	☐ Allergy-Local Anesth	☐ Alzheimer's/Dementia	☐ Anemia
☐ Angina/Chest Pain	☐ Arthritis	☐ Asthma	☐ Atrial Fibrillation
☐ Autoimmune Disease	☐ Back Problems	☐ Biologic Medications	☐ Bisphosonate Meds
☐ Blood Disease	☐ Blood Thinner Meds	☐ Bruise Easily	☐ Cancer
☐ Celiac Disease	☐ Chemical Dependency	☐ Chemotherapy	☐ Cold Sores
☐ Crohns Disease	☐ Depression/Anxiety	☐ Diabetes	☐ Dizziness/Fainting
☐ Emphysema/COPD	☐ Endocarditis	☐ Epilepsy/Seizures	☐ Excessive Bleeding
☐ Fen-Phen Medications	☐ Fibromyalgia	☐ Glaucoma	☐ HIV+/AIDS
☐ Headaches	☐ Heart Attack	☐ Heart Bypass	☐ Heart Disease
☐ Heart Murmur	☐ Heart Valve Replaced	☐ Hepatitis -Type ___	☐ High Blood Pressure
☐ High Cholesterol	☐ Hypoglycemia	☐ Joint Replacement	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Menopause	☐ Mitral ValveProlapse
☐ Osteopenia	☐ Osteoporosis	☐ PREMED	☐ Pacemaker
☐ Radiation Treatment	☐ Rheumatic Fever	☐ Rheumatism	☐ STD / HPV
☐ Seasonal Allergies	☐ Sinus Problems	☐ Sleep Apnea	☐ Smoker/ Chew Tobacco
☐ Stomach Problems	☐ Stroke	☐ Swelling of Limbs	☐ TMJ/Joint Pain
☐ Thyroid Condition	☐ Tuberculosis	☐ Tumors	☐ Ulcers

☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant):

_____

_____

_____

Do you use Tobacco or Nicotine? If yes, check all that apply;

☐ Smoking ☐ Chewing ☐ Vaping

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you take antibiotic premedication for your dental visits? If yes, please explain below. * ◯ Yes ◯ No

PRE-MED

_____

_____

Are you taking any medications (prescription or non-prescription) including vitamins/supplements, aspirin, or birth control pills? If yes, please list below. *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Have you taken or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Prolia etc. If yes, please enter the drug in the Medications list above. *

◯ Yes ◯ No

Do you have any allergies not listed above (including allergies to medications)? If yes, please explain below * ◯ Yes ◯ No

Please list any Allergies not listed above. (medications, food, etc.)

_____

_____

Name and phone number of your Physician:

_____

_____

Name and phone number of preferred Pharmacy:

_____

_____

In an emergency who should be notified? Please enter the name, relationship to patient, and phone number below:

_____

_____

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

_____

_____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

******FOR EXISTING PATIENTS ONLY******
PLEASE REVIEW AND MAKE ANY NECESSARY UPDATES

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Dental Insurance

Primary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

☐ * **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Please type name and date in box below. *

Response Date: _____