 Welcome Medical History images5.jpg

(Please complete form in its entirety)

|  |  |  |
| --- | --- | --- |
| Name: | Male/Female | Today’s Date |
| Date of birth: | Social Security #   * - | Occupation/Employer |
| Single/Married/Divorced/Widowed/ Minor |

|  |  |  |  |
| --- | --- | --- | --- |
| Street Address: | | | Who may we THANK for referring you to our practice? |
| City: | State: | Zip Code: | |
| Home Telephone: | Cell: | Work: | |
| Email Address: | | | |

**Student Status 26>**

|  |  |
| --- | --- |
| Full / Part Time | Name of School: |

**Spouse/Parent/Guardian Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Spouse/Parent /Guardian Name: | | | Parent /Guardian (2) Name: | | |
| Address: | | | Address: | | |
| City | State | Zip | City | DE | Zip |
| Telephone: | | | Telephone: | | |
| Date of birth: | | | Date of birth: | | |

**Insurance Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Primary Insured Name | | Date of Birth: | SSI# | |
| Employer: | | Insurance Company Name: | | |
| Insurance Company Telephone#: | | | | Insurance ID# |
| Group Number: |  | | | |
| Secondary Insured Name | | Date of Birth: | SSI# | |
| Employer: | | Insurance Company Name: | | |
| Insurance Company Telephone#: | | | | Insurance ID# |
| Group Number: |  | | | |

**\*Please allow our staff to make a copy of your identification card and dental insurance card\***

**Turn Over>>**

**Medical History**

|  |  |
| --- | --- |
| Physician Name: | Physician Telephone Number: |
| Emergency Contact: | Emergency Contact Telephone Number: |

List of current medication:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| Are you generally in good health? | | | Yes / No |
| Do you have any food, medication, metal, latex allergies? | | | Yes / No |
| Are you currently under a physicians care? For? | | | Yes / No |
| Have you had any surgeries in the last 2 years? | | | Yes / No |
| Have you had an orthopedic total joint replacement? (hip, knees, elbow, fingers) | | | Yes / No |
| Has a physician or dentist recommended that you take antibiotic prior to dental visits? If yes, what do you take? | | | Yes / No |
| Have you ever had any adverse reactions to dental procedures? | | | Yes / No |
| Have you ever had any adverse reactions to dental anesthia? | | | Yes / No |
| Are you pregnant? Yes/No If yes, what trimester | | OBGYN Telephone Number: ( ) - |  |
| Artificial heart valve | Yes / No | Bronchitis | Yes / No |
| Endocarditis | Yes / No | Emphysema | Yes / No |
| Congenital heart disease | Yes / No | Sinus trouble | Yes / No |
| Cardiovascular disease | Yes / No | Cancer/Chemo/Radiation Treatment | Yes / No |
| Angina | Yes / No | Chest pain upon exertion | Yes / No |
| Arteriosclerosis | Yes / No | Chronic pain | Yes / No |
| Congestive heart failure | Yes / No | Diabetes  Type I or II (Circle) | Yes / No |
| Damaged heart valves | Yes / No | Eating disorder | Yes / No |
| Heart attack | Yes / No | Gastrointestinal disease | Yes / No |
| Heart murmur | Yes / No | Reflux/Heartburn | Yes / No |
| Blood Pressure  Low / High (Circle one) | Yes / No | Ulcers | Yes / No |
| Other congenital heart defects | Yes / No | Thyroid Problems | Yes / No |
| Mitral valve prolapse | Yes / No | Stroke | Yes / No |
| Pacemaker | Yes / No | Glaucoma | Yes / No |
| Rheumatic fever | Yes / No | Hepatitis A ,B , C (Please circle)  Jaundice or liver disease | Yes / No |
| Rheumatic heart disease | Yes / No | Epilepsy | Yes / No |
| Abnormal bleeding | Yes / No | Fainting spells or seizures | Yes / No |
| Anemia | Yes / No | Neurological disorders (specify) | Yes / No |
| Blood transfusion If yes, date: | Yes / No | Do you snore? | Yes / No |
| Hemophilia | Yes / No | Mental health disorder (specify) | Yes / No |
| AIDS or HIV infection | Yes / No | Recurrent infections (type) | Yes / No |
| Arthritis | Yes / No | Kidney problems | Yes / No |
| Autoimmune disease | Yes / No | Osteoporosis | Yes / No |
| Rheumatoid arthritis | Yes / No | Persistent swollen neck glands | Yes / No |
| Lupus | Yes / No | Severe headaches/ migraines | Yes / No |
| Asthma | Yes / No | Do you use tobacco? | Yes / No |
| **Do you**  Do you have any disease, condition, or problem not listed above that you think we should be aware of? Yes / No | | | |

**Authorization**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand SSED has an open door treatment policy for minor child and I understand that I may accompany my minor child into the treatment room or observe from a safe distance. I authorize the dentist/staff to release my information including diagnosis and the records for any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then what is actually billed for my services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependants. Note: This information is for official and medically-confidential use only and will not be released to unauthorized persons.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, herby grant permission to SSED to discuss diagnosis, treatment options, and financial arrangements with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship to Patient Name Relationship to Patient



|  |  |
| --- | --- |
| Signature: | Date: |

The highest compliment you can give us is referrals of your friends and family. To thank you, we will give you a $25 credit on your account to you towards your future dental work.