MEDICAL HISTORY FORM **Date ____/____/____**

Name: _____ Date of Birth____/_____/_____SS# _____

Address: _____ City _____ State_____ Zip_____

Sex: M F Height_____ Weight_____ Occupation: _____ Name of Spouse_____

Home phone ( ) _____Business Phone ( ) _____ Cell phone ( ) _____

Email Address: _____Who are you referred by? _____

For the following questions, circle yes or no, whichever applies? Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is: _____
   _____

6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills? ..... Yes No
   a. Have you ever taken Bisphosphonate? - (Boniva, Fosamax, Zometa, ,Aredia) ..... Yes No
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Rheumatic Heart Disease ..... Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
      1. Chest pain upon exertion? ..... Yes No
      2. Shortness of breath after mild exercise? ..... Yes No
      3. Do your ankles swell? ..... Yes No
   d. Allergies ..... Yes No
   e. Sinus trouble ..... Yes No
   f. Asthma or hay fever ..... Yes No
   g. Fainting spells or seizures ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice or liver disease ..... Yes No
   j. Frequent or recurring mouth sores ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc ..... Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
   n. Stomach ulcer or hyperacidity ..... Yes No
   o. Kidney trouble ..... Yes No
   p. Tuberculosis ..... Yes No
   q. Persistent cough or cough that produces blood ..... Yes No
   r. Persistent swollen neck glands ..... Yes No
   s. Low blood pressure ..... Yes No
   t. Epilepsy or neurological disorder ..... Yes No
   u. Are you taking vitamins or homeopathic remedies ..... Yes No
   v. Cancer ..... Yes No
   w. AIDS or HIV infection ..... Yes No
9. Have you had abnormal bleeding? ..... Yes No

a. Have you ever required a blood transfusion? Yes No
10. Do you have any blood disorder such as anemia? Yes No
11. Have you ever had treatment for a tumor or growth? Yes No
12. Are you allergic to or have you had a reaction to:
    a. Local anesthetics Yes No
    b. Penicillin or antibiotics Yes No
    c. Sulfa drugs Yes No
    d. Barbiturates or sleeping pills Yes No
    e. Aspirin Yes No
    f. Iodine Yes No
    g. Codeine or other narcotics Yes No
    h. Latex or rubber products Yes No
    i. Other Yes No
13. Have you had any serious trouble associated with previous dental treatment? Yes No
    If so, explain:_____
    _____
14. Do you have any other condition or disease you think the doctor should know about? Yes No
    If so, explain:_____
15. Are you wearing contact lenses? Yes No
16. Are you wearing removable dental appliances? Yes No
17. Do you smoke? Yes No

Women

18. Are you pregnant or trying to become pregnant Yes No
19. Do you have problems associated with your menstrual period? Yes No
20. Are you nursing? Yes No
21. Are you taking birth control pills? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Relationship to Pt _____ Date: ____/____/_____

We only accept assignment of benefits on those insurance companies we participate in.

Insurance information:

Medical: _____ID # _____

Claim Mailing Address _____

Dental: _____ID # _____

Claim Mailing Address_____

Policy Holder Name_____SS#_____-_____-_____DOB_____/_____/_____

Relationship to patient_____ Employer_____

Is there secondary insurance: Yes No (If yes provide info) _____

I authorize Dr. John S. McIntyre D.M.D., PC to perform an Oral and Maxillofacial examination for the purpose of diagnosis and treatment planning. I authorize the taking of all x-rays required as a necessary part of this examination. I authorize the release of any information acquired in the course of my examination and treatment to any of my treating doctors or for insurance purposes.

I hereby assign to Dr. John S. McIntyre, D.M.D., PC all payments for Medical/Dental services rendered to myself or my dependent. I also understand that I am responsible for co-payments, deductibles, coinsurance and any other fees or services not covered by my insurance.

Signature_____ Date____/_____/____