PATIENT MEDICAL HISTORY

Patient's Name: **Cell Phone:**

For Office Use Only
ID:

Address: **Today's Date:** **Date of Last Visit:** **Date of Med. History:**

City State Zip: **Email:**

Home Phone: **Work Phone:** **Birth Date:** **Social Security No.:** **Marital Status:**

For your Appointment Confirmation - Do you prefer:
○ **Call** ○ **Text** ○ **E-Mail**

Are you happy with your smile?
○ **Yes!** ○ **No. I'd like to change:**

Whom May We Thank for Referring You:

Physician Name: **Physician Phone:**

Pharmacy: **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Are you pregnant? If Yes, # of weeks ☐
☐ ☐ Are you nursing?

Please answer the following:

Y N
☐ ☐ Do you smoke or use tobacco?

Height: [ ]

For Office Use Only
BP [ ] Heart Rate: [ ] Weight: [ ]

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

Medications:

Y N ☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below…

POLICIES

Your appointment is reserved and requires a 48 hour notice of cancellation. We reserve the right to charge a fee of $50 for every ½ hour of missed appointments for this time.

You agree that we may release information to the insurance carrier regarding your records.

Payment is due when services rendered.

All past due accounts of more than 30 days are subject to a 1.5% monthly finance charge.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS ENTIRE FORM, PROVIDED CORRECT INFORMATION, AGREE TO THE CONDITIONS LISTED ABOVE, AND THAT I UNDERSTAND THAT FILING INSURANCE CLAIMS IS MY RESPONSIBILITY.

_____ _____

PATIENTS SIGNATURE
(If minor, Parent/Guardian must sign)

DATE

I have reviewed the medical history:

_____ _____

DOCTOR'S SIGNATURE

DATE