MEDICAL HISTORY FORM

Patient Information

Mr. Ms. Dr. _____
(First) (Middle Initial) (Last)

Address: _____
(Street) (City) (State) (Zip)

Telephone: (H)_____ (W)_____ Cell Phone _____

Employer: _____ Occupation:_____

Birth date: _____ Social Security #:_____

Email Address: _____

Date of Last Dental Exam: _____ Were X-rays Taken?_____

Were You Referred To Our Office?_____ By Whom?_____

Information Regarding Party Responsible for Billing (if not yourself)

Name: _____ Relationship:_____

Address:_____
(Street) (City) (State) (Zip)

Telephone: (H)_____ (W)_____

Insurance Information:

	Primary Insurance	Secondary Insurance
Insured's Name:	_____	_____
Insurance Company:	_____	_____
Insurance Address:	_____	_____
Company Name (Work):	_____	_____
Group # / Local #:	_____	_____

(OVER)

INDICATE ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

Yes	No		Yes	No		Yes	No	
___	___	Angina	___	___	Mitral Valve Prolapse	___	___	Heart Murmur
___	___	Stomach Ulcers	___	___	Fainting Spells	___	___	Anemia
___	___	Arthritis/Rheumatism	___	___	Dizzy Spells	___	___	Stroke
___	___	Liver Disease	___	___	Kidney Trouble	___	___	Glaucoma
___	___	HIV/AIDS	___	___	Sinus Trouble	___	___	Diabetes
___	___	Artificial Joints	___	___	Pain in Jaw	___	___	Hemophilia
_____		Psychiatric Care	___	___	Bruise Easily	___	___	Drug Addiction
___	___	Heart Attack	___	___	Rheumatic Fever	___	___	Chemotherapy
___	___	Thyroid Disease	___	___	Heart Disease	___	___	Heart Failure
___	___	Hepatitis	___	___	Tuberculosis	___	___	High Blood Pressure
___	___	Blood Transfusion	___	___	Venereal Disease	___	___	Asthma/Emphysema

ARE YOU ALLERGIC OR HAVE YOU EVER REACTED ADVERSELY TO ANY OF THE FOLLOWING: Please check here if there are no allergies to any medicines ☐

Local Anesthetic	Penicillin	Tetracycline	Nickel
Aspirin	Latex	Codeine	Erythromycin

IS THERE ANYTHING ELSE IN YOUR MEDICAL HISTORY THAT WE SHOULD KNOW ABOUT?

_____

List all medications you are presently taking:

_____

Have you ever had excessive bleeding or complications following dental treatment? _____

Who is your Physician?_____ Telephone:_____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT'S SIGNATURE_____ DATE_____

UPDATED _____ _____

UPDATED _____ _____

UPDATED _____ _____

UPDATED _____ _____

I understand that a $100.00 fee will be charged for appointments broken or cancelled with less than 24 hours notice. All balances over 90 days old will be subject to a 1% monthly finance charge.

PATIENT'S SIGNATURE_____ DATE_____

"Unless otherwise noted, I hereby assign all insurance benefits for treatment rendered directly to Edward D. Paul, D.D.S., M.S. I understand I will be responsible for the balance of the charge."

PATIENT'S SIGNATURE: _____ DATE: _____