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PATIENT INFORMATION

Name _____ Marital Status _____ Spouse: _____
Address _____ City _____ State/Zip _____
Birthdate _____ Sex M F Home Phone () _____ - _____
Relationship to financially responsible party: Work Phone () _____ - _____
SELF SPOUSE CHILD OTHER Social Security Number _____ - _____ - _____
If college student, school name _____
Employer _____

RESPONSIBLE PARTY

Name _____
Address _____
City _____ State _____ Zip _____
Mailing Address(if different) _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____

PRIMARY DENTAL INSURANCE

(policyholder's)
Group Number _____ Social Security Number _____ - _____ - _____
Policyholder/Employee: _____ Employee's Birthdate _____
Employer _____ Others covered _____
Emp. Address _____
City _____
State _____ Zip _____ Emp. Phone () _____ - _____
Insurance Company _____

SECONDARY DENTAL INSURANCE

(policyholder's)
Group Number _____ Social Security Number _____ - _____ - _____
Policy holder/Employee _____ Employees Birthdate _____
Employer _____ Others covered _____
Emp. Address _____
City _____
State _____ Zip _____ Emp. Phone () _____ - _____
Insurance Company _____

MEDICAL HISTORY FORM

Are you in good health..... YES NO
Has there been any changes in your general health within the past 2 years?..... YES NO
Are you taking any medication(s) including any non-prescription medications, vitamins..... YES NO
supplements, or herbs? Please list all medications you are taking?_____

Have you been treated or hospitalized for a serious illness, injury, or surgery within the past 2 years..... YES NO
if so, for what?_____

The name and phone number of your physician is?_____

Do you have or have you had any of the following disease or conditions?

Heart disease (heart trouble, heart attack

chest pain, bypass surgery, pacemaker) Y N

Tuberculosis Y N

Damaged heart valves or artificial heart

Epilepsy, or other

valves, heart murmur, rheumatic heart disease, mitral valve prolapse Y N

Stroke Y N

High Blood Pressure Y N

Diabetes Y N

Allergies, hayfever, asthma, sinus trouble Y N

Respiratory problems, emphysema, bronchitis, shortness of breath Y N

Hepatitis, jaundice, or liver disease Y N

Thyroid problems Y N

Stomach problems, ulcers, etc. Y N

Kidney or urinary problems Y N

Are you **allergic** or have you had a reaction to:

Local anesthetics Y N

Penicillin Y N

Other antibiotics Y N

Sulfa drugs Y N

Aspirin Y N

Codeine or other narcotics Y N

Sedatives or sleeping pills Y N

Other_____ Y N

Neurological disease Y N

Fainting spells or seizures Y N

Cancer Y N

Glaucoma or other eye disease Y N

Arthritis Y N

Abnormal or excessive bleeding Y N

Anemia, or other blood disorder Y N

AIDS or HIV infection Y N

Tumor or other growth Y N

Psychological problems Y N

Blood Transfusion Y N

Sexually transmitted disease Y N

Other_____ Y N

Have you had a total knee or **hip replacement?** Y N

If so when?_____ Y N

Are you on a **blood thinner?** Y N

Women:

Are you pregnant? Y N

Are you nursing? Y N

Are you taking any birth control pills? Y N

What is the purpose of today's visit?_____

When was your last dental visit_____Where?_____

Is there any information that should be known about previous visits?_____

Do you grind or clench your teeth? Y N

Do you have pain in the jaws? Y N

Do you like your smile? Y N

Do you have bleeding gums? Y N

Do you feel your dental health is good? Y N

Have you ever had an unpleasant Dental experience? Y N

I understand that the above information that I have given is correct to the best of my knowledge and that this information is necessary for my best care. This information will be kept confidential. I hereby authorize payment, directly to the doctor, of any insurance benefits to which I am entitled.

Signature (if child, parent or guardian)_____ Date_____

Who may we thank for referring you to Hannibal Dental Group?_____