PATIENT OF RECORD
MEDICAL/DENTAL HISTORY UPDATE

Medical Alert

So that we may provide you with the best possible care, please complete both sides of this medical/dental history update.

(PLEASE PRINT)

Pharmacy Name_______________Phone_______________

Date_______________ Home Phone_______________ Work Phone _______________

Patient Name ____

Last First Initial Name Called By

Address ____

City_______________ State_____ Zip_______ Social Security #_______________ Driver's Lic.#_______________

Sex: ❑ Male ❑ Female Age_____ Birthday __/__/__ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed By______________________________ Occupation________________________

Business Address____

City_______________ State_____ Zip_______ Tel._______________

Spouse Name____________________ Birthday __/__/__ Employed By________________________

Business Address____

City_______________ State_____ Zip_______ Tel._______________ Social Security #_______________

Who is responsible for this account?________________________ Relationship to Patient_______________

In case of emergency, who should be notified? ________________________ Tel._______________

Whom may we thank for referring you? ____

Dental Insurance

Dental Insurance Primary Carrier

Insured's Name __________ Social Security # __________

Insurance Company __________

Address __________

City __________ State __________ Zip __________

Group Number __________ ID Number __________ Birthdate __________

Insured's Employer __________

Dental Insurance Secondary Carrier

Insured's Name __________ Social Security # __________

Insurance Company __________

Address __________

City __________ State __________ Zip __________

Group Number __________ ID Number __________ Birthdate __________

Insured's Employer __________

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Patient Name

MEDICAL HISTORY UPDATE

Date of Last Physical____________________

Physician's Name____________________

Address____________________

____________________ Tel.__________

Please check the box of any condition you may have had.

❑ Heart Disease or Attack	❑ Allergies to Anesthetics	❑ Kidney Problem
❑ Heart Murmur	❑ Contact Lenses	❑ Thyroid Disease
❑ Heart Pacemaker	❑ Hypoglycemia	❑ Glaucoma
❑ Angina Pectoris	❑ Artificial Heart Valves	❑ Diabetes
❑ Mitral Valve Prolapse	❑ Artificial Joints	❑ Arthritis/Rheumatism
❑ High Blood Pressure	❑ Recent Weight Loss	❑ Allergy to Colored Dyes
❑ Low Blood Pressure	❑ General Allergies	❑ Special Diet
❑ Circulatory Problems	❑ Blood Disease	❑ Swollen Neck Glands
❑ Asthma	❑ Back Problems	❑ Rheumatic Fever
❑ Hepatitis, Jaundice or Liver Disease	❑ Nervous Problems	❑ Sinus Problems
❑ Epilepsy/Seizures	❑ Psychiatric Care	❑ Ulcer
❑ Stroke	❑ Allergy to Latex	❑ Venereal Disease
❑ Headaches	❑ "A.I.D.S."/ HIV Positive or Other	❑ Chemical Dependency
❑ Cancer, Leukemia	❑ Tuberculosis	❑ Hemophilia
❑ Chronic Diarrhea	❑ Respiratory Problem	❑ Blood Transfusion

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? ❑ Yes ❑ No

If yes, list____________________

Have you ever responded adversely to medical or dental treatment? ❑ Yes ❑ No

Are you taking any medication at this time? ❑ Yes ❑ No

If yes, what____________________

Have you ever taken Phen-Fen? ❑ Yes ❑ No

If so, have you seen a cardiologist for a consult since taking it? ❑ Yes ❑ No

Are you under the care of a physician? ❑ Yes ❑ No

If yes, for what condition____________________

Women — Are you: Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

Have you had a recent transfusion? ❑ Yes ❑ No

Is there anything else we should know about your medical history____________________

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing & processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers &/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____________________ __________

Signature of patient or parent of mino Date