

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 _____

Address _____ Last First Initial Name Called By

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 _____

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.

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

Date _____