



# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Chart # \_\_\_\_\_

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone Number \_\_\_\_\_

How did you hear about The Smile Center? \_\_\_\_\_

When was your last dental exam \_\_\_\_\_ Dentist's Name \_\_\_\_\_

Why have you come to see us today? \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been involved in a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes, please explain: \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, please explain: \_\_\_\_\_

Do you use tobacco?  Yes  No If yes, please explain: \_\_\_\_\_

Do you use controlled substances?  Yes  No If yes, please explain: \_\_\_\_\_

Have you received or are you currently receiving any of the following drugs: Fosamax, Actonel, Boniva, Aredia or Zometa?  Yes  No If yes, please explain: \_\_\_\_\_

Do you require a PreMed?  Yes  No If yes, please explain: \_\_\_\_\_

Women: Are you...

<input type="checkbox"/> Pregnant / Trying to get pregnant?	<input type="checkbox"/> Nursing?	<input type="checkbox"/> Taking oral contraceptives?
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Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Other, please explain: _____

Comments: \_\_\_\_\_

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Do you have, or have you had, any of the following?

<input type="checkbox"/>	AIDS / HIV Positive	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	Cold Sores / Fever Blisters	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	Congenital Heart Disorder	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	Heart Attack / Failure	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Spina bifida
<input type="checkbox"/>	Arthritis / Gout	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Stomach / Intestinal Disease
<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Pace Maker	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	Swelling of Limbs
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	Tumors or Growths
<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	Fainting Spells / Dizziness	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	Yellow Jaundice

Have you ever had any serious illness not listed above?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, please explain: _____
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Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my ( or patient's ) health. It is my responsibility to inform the dental office of any changes in medical status.

Do you have a guardian?  YES  NO Relationship \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ UPDATE \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ UPDATE \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ UPDATE \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ UPDATE \_\_\_\_\_

Personal Information Sheet

Chart # \_\_\_\_\_
Date \_\_\_\_\_
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_
Telephone # \_\_\_\_\_ Work # \_\_\_\_\_ May we call you at work? Y N
Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Insurance Name \_\_\_\_\_ Employer \_\_\_\_\_
Group # \_\_\_\_\_ Effective Date \_\_\_\_\_ Relationship to Subscriber \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can effect my insurance payment. It is my responsibility to inform the dental office of any changes in my insurance coverage.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

To be completed by office staff

Insurance Breakdown

Yearly Maximum \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_ Calendar Year \_\_\_\_\_ Individual / Family
Preventive \_\_\_\_\_ %
Frequencies:
Cleanings: every 6 months / twice per year Exams: \_\_\_\_\_ every \_\_\_\_\_ Mo / Yr
Bitewings: \_\_\_\_\_ Pano / FMX \_\_\_\_\_
Is Oral Hygiene Instruction Covered? Yes No
Fluoride \_\_\_\_\_ % up to the age \_\_\_\_\_ How Often? \_\_\_\_\_
Sealants \_\_\_\_\_ % up to the age \_\_\_\_\_ How Often? \_\_\_\_\_
Are sealants paid on: Baby Teeth Permanent Molars Only Pre-Molars
Restorative \_\_\_\_\_ %
Posterior composites \_\_\_\_\_ % downgrade to amalgam? Yes No Write-Off: Yes No
Endo \_\_\_\_\_ %
Perio \_\_\_\_\_ %
Code 4341 \_\_\_\_\_ % can all 4 quads be done in the same day? \_\_\_\_\_
Code 4355 \_\_\_\_\_ % Code 9630 \_\_\_\_\_ % Code 4910 \_\_\_\_\_ % How often? \_\_\_\_\_
Oral Surgery \_\_\_\_\_ % difference in surgical vs. simple? \_\_\_\_\_
Major \_\_\_\_\_ % Pre-auth required / recommended? Yes No
Buildup Code 2950 \_\_\_\_\_ %
Partials / Dentures \_\_\_\_\_ %
Prosth. Replacement every \_\_\_\_\_ years
Ortho \_\_\_\_\_ % Age min \_\_\_\_\_ Age max \_\_\_\_\_ Ortho Max \$ \_\_\_\_\_
Missing tooth clause? Yes No
Waiting Periods? Yes No If yes, how long? \_\_\_\_\_
What address should we send the claim to? \_\_\_\_\_
Any history? \_\_\_\_\_
Last Exam \_\_\_\_\_ Last Prophy \_\_\_\_\_ Last Pano / FMX \_\_\_\_\_ Last BWX \_\_\_\_\_