

# Patient Information and Medical History

**Name** **Home Phone** **Cell Phone** **Work Phone**

**Mailing Address** Street Apartment # or Floor City/Town State Zip

**Date of Birth** Age/ Sex Social Security # Driver's License # Marital Status

**Student**/School Name School Location School Address City/Town State Zip

**Employed**/ Employer's Name Employer's Address City/Town State Zip

**Family Members** (who have been seen here)

**Referred by:**  **Dentist** (Name)  **Orthodontist** (Name)  **Physician** (Name)

**Responsible Party Information** (if different from Patient Information above and/or Parent or Legal Guardian with Patient under 18 at time of Surgery)

**Name** Home Phone Relationship (self/child/spouse)

**Mailing Address** Street Apartment #/Floor City/Town State Zip

**Date of Birth** Social Security Number

**Employed**/Employer's Name Employer's Address City/Town State Zip

## Primary Dental Insurance Company

Policy Holder: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_

Insurance Mailing Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

## Secondary Dental Insurance Company

Policy Holder: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

**Secondary** Dental Insurance Company: \_\_\_\_\_

Insurance Mailing Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

## Primary Medical Insurance Company

Policy Holder: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Insurance Mailing Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

## Secondary Medical Insurance Company

Policy Holder: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

**Secondary** Medical Insurance Company: \_\_\_\_\_

Insurance Mailing Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

**1. Are you in good health?** Y N

**2. Have there been any changes in your general health in the past year?** Y N

(If yes, please list) \_\_\_\_\_

\_\_\_\_\_

**3. Date of last physical exam?** \_\_\_\_\_

**4. Are you under a physician's care for a particular problem?** Y N

(If yes, what for) \_\_\_\_\_

\_\_\_\_\_

**5. Have you had any serious illnesses, operations or hospitalization?** Y N

(If yes, describe) \_\_\_\_\_

**6. Have you had any adverse effects from dental treatment?** Y N

**7. Do you smoke or chew tobacco?** Y N

(How much daily) \_\_\_\_\_

**8. Do you use alcohol?** Y N

(How much) \_\_\_\_\_

**9. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders?** Y N

**10. Women**

A. Are you pregnant or planning pregnancy? Y N

B. Are you taking birth control pills? Y N

C. Are you taking hormone replacements? Y N

**11. Do you wish to talk to the doctor privately about anything?** Y N

(If yes, describe) \_\_\_\_\_

\_\_\_\_\_

**12. Do you have or have you ever had?**

A. Rheumatic Fever or Rheumatic Heart Disease Y N

B. Congenital Heart Disease Y N

C. Cardiovascular Disease (heart trouble, heart angina, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker) Y N

D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing) Y N

E. Seizures, Convulsions, Epilepsy, Fainting, Psychiatric Treatment, Dizziness, Nervous Disorder or Breakdown Y N

F. Do you bruise easily Y N

G. Liver Disease (Jaundice, Hepatitis) Y N

H. Kidney Disease Y N

I. Diabetes Y N

J. Thyroid Disease Y N

K. Arthritis Y N

L. Stomach Ulcers or Colitis Y N

M. Glaucoma Y N

N. Frequent or Recurring Mouth Sores Y N

O. Implants placed *anywhere* in your body (heart valve, hip, knee), mouth Y N

P. Radiation (X-Ray) treatment for cancer Y N

Q. Clicking or popping of jaw joint, pain near ear difficulty opening mouth, grinding or clenching of teeth Y N

R. Sinus or Nasal Problems Y N

S. Any disease(s), drug(s) or transplant operation(s) that have depressed your immune system Y N

T. Recurrent infections of any kind Y N

U. Problems with your immune system Y N

Physician's Notes:

**13. Are you taking any of the following?**

A. Medication for Acid Reflux or Indigestion	Y	N
B. Thyroid Medications	Y	N
C. Antibiotics	Y	N
D. Anticoagulants	Y	N
E. High Blood Pressure	Y	N
F. Steroids (Cortizone, etc)	Y	N
G. Tranquilizers (Valium, etc)	Y	N
H. Insulin, Diabinese, or similar drug	Y	N
I. Digitalis, Inderal, Nitroglycerin, Calcium Channel Blockers, or other heart medicine	Y	N
J. Aspirin, Ibuprofen (Motrin, Naprosyn, etc.)	Y	N
K. Marijuana or other "street drugs"	Y	N
L. Antihistamines or decongestants	Y	N
M. Medication for Osteoporosis	Y	N
N. Are you taking any other regular medications, pills, or drugs?	Y	N
(If yes, please list) _____		

**14. Are you allergic or have had a bad reaction to?**

A. Local anesthetic (novocaine, etc,)	Y	N
B. Penicillin, amoxicillin, cephalosporins or other antibiotics	Y	N
C. Barbituates, sedatives, etc	Y	N
D. Aspirin or Ibuprofen	Y	N
E. Codeine or other pain killers	Y	N
F. Latex or rubber products	Y	N
G. Other allergies or reactions	Y	N
(If yes, please list) _____		

**15. Do you have any other disease, condition or problem** - not listed above that you think the doctor should know about?

	Y	N
_____		
_____		
_____		

**Accident Information (if visit is related to an accident)**

Patient Name: \_\_\_\_\_

Account #: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Accident Related to:  Work  Auto

Other \_\_\_\_\_

Insurance Company : \_\_\_\_\_ Claim # \_\_\_\_\_

Attorney/Adjustor Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Brief Description of Accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Payments, Fees & Insurance**

**I authorize** my insurance company to pay benefits to Great Bay Oral Surgery Associates, PA and that any balance after my insurance has paid is *my responsibility*.

**I understand** that I am responsible for service rendered to myself or my dependent at the time of service.

Signature of Policy Holder: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

**Medical History Accuracy**

**I understand the importance of a truthful health history** to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

Signature of person completing health history \_\_\_\_\_ Dr.'s initials \_\_\_\_\_

**Medical Update: I have read my medical history dated** \_\_\_/\_\_\_/\_\_\_ **and confirm that it adequately states past and present conditions.**

