MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: ***(Mr./Mrs./Ms./Miss./Dr.)***

DATE OF BIRTH (MONTH/DAY/YEAR):

ADDRESS (HOME):

HOME PHONE:

CELL PHONE:

EMAIL ADDRESS:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE:

IN CASE OF EMERGENCY WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAYTIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE:

ADDRESS:

(1)NAME OF MEDICAL SPECIALIST:

AREA OF SPECALITY:

PHONE/ADDRESS:

(2)NAME OF MEDICAL SPECIALIST:

AREA OF SPECALITY:

PHONE/ADDRESS:

The following information is require to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so,why?

__YES __NO __NOT SURE/MAYBE

2. When was your last medical checkup?

3.Has there been any change in your general health in the past year? If yes, please explain.

__YES __NO __NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

__YES __NO __NOT SURE/MAYBE

5. Do you have any allergies? If yes, please list below.

a)medications **__YES __NO __NOT SURE/MAYBE**

b)latex/rubber products

c)other (e.g. hayfever, foods, etc?)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

__YES __NO __NOT SURE/MAYBE

7. Do you have or have you ever had asthma?

__YES __NO __NOT SURE/MAYBE

8. Do you have or have you ever had heart or blood pressure problems?

__YES __NO __NOT SURE/MAYBE

9. Do you or have you ever had a heart murmur, mitral valve prolapse, or rheumatic fever?

__YES __NO __NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint?

__YES __NO __NOT SURE/MAYBE

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?

__YES __NO __NOT SURE/MAYBE

12. Do you have any conditions or therapies that could affect your immune system?
(e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy, etc?) **__YES __NO __NOT SURE/MAYBE**

13. Do you have a bleeding problem or bleeding disorder?

__YES __NO __NOT SURE/MAYBE

14. Have you ever been hospitalized for any illness or operations? If yes, please explain.

__YES __NO __NOT SURE/MAYBE

15. Do you have or have you ever had any of the following ? Please Check.

__diabetes
__cancer
__stroke
__arthritis
__pacemaker
__heart attack
__lung disease
__thyroid disease
__kidney disease
__shortness of breath
__chest pain, angina
__prosthetic heart valve
__drug/alcohol dependancy
__diet pill therapy
__steroid therapy
__stomach ulcers
__tuberculosis
__seizures (epilepsy)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?

__YES __NO __NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family?
(e.g. diabetes, cancer, heart disease, etc)

__YES __NO __NOT SURE/MAYBE

18. Do you smoke or chew tobacco products?

__YES __NO __NOT SURE/MAYBE

19. Are you nervous during dental treatment? **__YES __NO __NOT SURE/MAYBE**

20. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?

__YES __NO __NOT SURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT OR PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

Some dental insurance companies allow transmission and/or assignment of dental claims, if you wish to use this feature please sign the following.

I hereby assign my benefits payable from claims submitted electronically to Dr.____________________ and authorize payment directly to him/her.

Signature of Subscriber
Date:____________ Patient ID:_____________

I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.

Signature of Subscriber
Date:______________ Patient ID:_______________

DENTIST'S NOTES: