Medical History for New Patient

Last Name: First Name: Birthdate:

Name of Medical Doctor: -------------------------------- City/State: ---------------------------

Emergency Contact ______ Phone ______ Relationship ______

List all medications that you are now taking:

______ ______
______ ______
______ ______
______ ______
______ ______

Do you take a premedication prior to dental ______

Are you allergic to any of the following?

Y	Y
☐ Anesthetic	☐ Penicillin/Amoxicillin
☐ Aspirin	☐ Sulfa
☐ Codeine	☐ Latex
☐ Other: ______	

Do you have any of the following medical conditions?

Y	Y	Y
☐ Asthma	☐ Kidney Disease	☐ Frequent Headaches
☐ Bleeding Problems	☐ Liver Disease	☐ Osteoporosis/Osteopenia
☐ Cancer	☐ Pregnancy	☐ Radiation Treatment
☐ Diabetes Type I or II	☐ Psychiatric Treatment	
☐ Heart Murmur	☐ Sinus Trouble	
☐ Heart Trouble	☐ Stroke	
☐ High Blood Pressure	☐ Ulcers	
☐ Joint Replacement	☐ Rheumatic Fever	

List any other conditions: ______

Recent surgery: ______

Tobacco use? If so, what kind and how ______

Unusual reaction to dental ______

Reason for today's ______ Are you in ______

New

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years ______

Do you have BiteWing x-rays that are less than 1 year ______

Name of former dentist ______ City/State ______

Date of last cleaning and ______

Date: 08/16/2016

Patient Signature: ______

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name____
Last First MI (Preferred)

Birthdate______________ SS#__________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone________________ Wireless Phone__________________ Wireless Carrier________________

Email____

Preferred contact method [ ] HmPhone [ ] WkPhone [X] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [X] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [X] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address____

Address 2____

City__________________________ State_MN____Zip__________________

Home Phone_______________________

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name__________________________________Subscriber ID # _____________________

Insurance Company ____________________________________Phone__________________________

Employer________________________Group Name____________________Group #________________

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name__________________________________Subscriber ID # _____________________

Insurance Company ____________________________________Phone__________________________

Employer________________________Group Name____________________Group #________________

Comments: