Health History / Personal Information

Male ❑ Female ❑ Child ❑ Single ❑ Married ❑

PATIENT'S NAME _____ DATE OF BIRTH _____

RESPONSIBLE PARTY Self ❑ Parent ❑ Guardian ❑

NAME (OF RESPONSIBLE PARTY) _____

ADDRESS _____

CITY / STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS (FOR APPOINTMENT REMINDERS ONLY) _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

EMERGENCY CONTACT _____ EMERGENCY PHONE _____

OCCUPATION _____ WORK PHONE _____

REFERRED BY _____

PRIMARY INSURANCE (Please notify us if you have a secondary insurance.)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

DENTAL INSURANCE COMPANY _____

GROUP NUMBER _____

SUBSCRIBER NAME _____

SUBSCRIBER EMPLOYER _____

SUBSCRIBER SOCIAL SECURITY # _____

SUBSCRIBER ID # _____

SUBSCRIBER DATE OF BIRTH _____

NAME OF SPOUSE / GUARDIAN _____

EMPLOYER OF SPOUSE / GUARDIAN _____

Your dental and medical history are important. Many things have a direct bearing on your dental health. The information you provide is confidential and will not be released without your permission.

1. Name, phone number, and address of your Physician: _____

2. Are you taking any prescription / over-the-counter drug(s)? **YES** ❑ **NO** ❑ If yes, please list each one: _____

3. Have you ever been treated for any of the following:

Anemia ..... **YES** ❑ **NO** ❑	Diabetes ..... **YES** ❑ **NO** ❑	High Blood Pressure ..... **YES** ❑ **NO** ❑
Angina ..... **YES** ❑ **NO** ❑	Drug Addiction ..... **YES** ❑ **NO** ❑	Kidney Problems ..... **YES** ❑ **NO** ❑
Arthritis/Gout ..... **YES** ❑ **NO** ❑	Epilepsy or Seizures ..... **YES** ❑ **NO** ❑	Liver Disease ..... **YES** ❑ **NO** ❑
Artificial Heart Values ..... **YES** ❑ **NO** ❑	Glaucoma ..... **YES** ❑ **NO** ❑	Stroke ..... **YES** ❑ **NO** ❑
Artificial Joints ..... **YES** ❑ **NO** ❑	Heart Attack/Failure ..... **YES** ❑ **NO** ❑	Tuberculosis ..... **YES** ❑ **NO** ❑
Asthma ..... **YES** ❑ **NO** ❑	Heart Murmur ..... **YES** ❑ **NO** ❑	Lung Disease ..... **YES** ❑ **NO** ❑
Blood Disease ..... **YES** ❑ **NO** ❑	Heart Pacemaker ..... **YES** ❑ **NO** ❑	Thyroid Disease ..... **YES** ❑ **NO** ❑
Cancer ..... **YES** ❑ **NO** ❑	Hemophilia ..... **YES** ❑ **NO** ❑	Ulcers ..... **YES** ❑ **NO** ❑
Congestive Heart Disorder ..... **YES** ❑ **NO** ❑	Hepatitis (A,B, or C) ..... **YES** ❑ **NO** ❑	

4. Are you currently taking or have you ever taken bisphosphonates, either orally or by I.V. ? (Examples: Fosamax, Boniva) **YES** ❑ **NO** ❑ **ORALLY** ❑ **I.V.** ❑

5. Are you allergic to any of the following: **Penicillin** ❑ **Aspirin** ❑ **Codeine** ❑ **Latex** ❑ **Dental Anesthetics** ❑

6. Please list any other drug(s) that you are allergic to: _____

7. Other physical conditions we should be aware of: _____

8. Women only: Are you pregnant or think you might be? **YES** ❑ **NO** ❑ Are you nursing? **YES** ❑ **NO** ❑

For Electronic Submission: I do hereby acknowledge that this transaction is being conducted by electronic means and by typing my name herein below or transmitting this document to American Dental, I am subscribing to this agreement and thereby providing my electronic signature. By typing my name in the space below or by the act of transmitting this document to American Dental, I intend to be bound by the terms and conditions of the doctor-patient agreement herein and the terms and conditions therein are in full force and effect and legally enforceable against me.

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence in accordance with HIPPA regulations and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

_____ _____

Patient's Signature or Legal Guardian (Type in name if submitting electronically) Date