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

Health History / Personal Information

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