Welcome to THE MEDICAL CENTER DENTAL GROUP

PATIENT INFORMATION

Name: _____ _____

Date of Birth: _____ Sex: [ ] M [ ] F Marital Status: [ ] Married [ ] Single

Social Security Number: _____ Driver's license number _____

Address: _____ _____

City: _____ State: _____ Zip: _____ Contact Preference: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Primary Care Physician: _____ PCP's phone number: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Not Employed

Employer: _____

Phone: _____

Job Position: _____

EMERGENCY CONTACT

Name: _____

Relationship _____

Phone: _____

RESPONSIBLE PARTY **(Must complete if responsible party is other than the insured or patient.)**

Name: _____ Employer: _____

Address: _____ Phone: _____

City, State, & Zip: _____ Date of Birth: _____

Social Security#: _____ Relation to Patient: _____

DENTAL INSURANCE **(We will need to make a copy of your insurance ID card)**
Must complete this information in its entirety in order for us to file with your insurance.

Name of Insured: _____ Relation to Patient: _____

Name of Insurance Company: _____ Insured SS#: _____

Insurance Phone #: _____ Policy Group #: _____

Insured Employer: _____ Insured Date of Birth: _____

How did you hear about us? Family/Friend (name) _____ Doctor (name) _____

Facebook ___ Twitter ___ Other internet site (name) _____ Other: _____

What are you looking for in a dental office or do you have any specific dental goals?

_____

I certify that this information is true and correct to the best of my knowledge. I further understand and agree that, regardless of any insurance coverage, I am ultimately responsible for the cost of any dental treatment.

Patient/Responsible Party Signature: Date:

_____ _____

Medical Health History

Patient Name: _____ **Birth date:** _____

1. My Medical Doctor is (NAME)_____ Phone_____

2. Have you had any serious illness or operation? YES NO Explain:_____

_____

3. Have you had any abnormal bleeding with tooth extraction or other surgery? YES NO

4. Do you bruise easily? YES NO

5. Have you ever had a transfusion? YES NO

6. **MEDICINES YOU ARE TAKING:**

Antibiotics	YES	NO
Coumadin or other blood thinners	YES	NO
Blood pressure medication	YES	NO
Digitalis or other heart drugs	YES	NO
Nitroglycerine	YES	NO
Antihistamines	YES	NO
Insulin or other med for diabetes	YES	NO
Cortisone or steroids	YES	NO
Oral contraceptives	YES	NO
Herbal Supplements	YES	NO
Vitamins	YES	NO

7. **Are you <u>ALLERGIC</u> to any of the following?**

Local anesthetics or numbing	YES	NO
Penicillin or other antibiotic	YES	NO
Sulfa drugs	YES	NO
Barbiturates or sleeping pills	YES	NO
Aspirin	YES	NO
Iodine	YES	NO
Codeine or other narcotic	YES	NO
Latex gloves	YES	NO
Sedatives	YES	NO
Alcohol	YES	NO
Narcotics	YES	NO

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Bisphosphonate drugs (Fosamax, Boniva, Aredia, Actonel, Zometa) used in cancer &osteoporosis treatment YES NO

8. Please list drugs you are **<u>ALLERGIC</u>** to:_____

9. Are you taking any medicines regularly? _____

10. Do you now have or have you had in the past any of the following diseases or problems?

___AIDS
___Asthma
___Cancer
___Chest pain on exertion
___Cold sores/fever blisters
___COPD
___Damaged heart valves
___Diabetes
___Diarrhea
___Dry mouth
___Epilepsy
___Excessive bleeding
___Frequent thirst
___GERD (Reflux Disease)
___Heart attack
___Hepatitis
___Herpes
___Other sexually transmitted disease
___High blood pressure
___Hives or rash
___HIV positive
___Kidney problems
___Osteoporosis
___Pacemaker
___Rheumatic fever
___Seizures
___Shingles
___Shortness of breath
___Sleep Apnea
___Smoke cigarettes
___Snoring
___Stroke
___Swollen ankles
___Swollen lymph nodes
___Syphilis
___Thrush
___Thyroid problems
___Tuberculosis
___Yeast infections
___Implants or replacements?
  ___Breast
  ___Joint (knee or hip)
  ___Dental
  ___Chin
  ___Other_____

11. WOMEN

___Pregnant at this time

___Nursing at this time

___Menstrual problems

___Menopause

12. **OTHER**

Anything else we should know about? _____

_____

I have read all the information on this sheet and have completed the answers. I affirm that this information is correct to the best of my knowledge and that I will inform my dentist of any changes in my health history and medicines prescribed to me. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature **Date**