Adult Medical History

Name_____Nickname_____ Spouse's Name_____
Address_____ Spouse's Soc Sec. No._____
City_____ State_____Zip Code_____ Spouse's Employer_____
Employer_____ Employer's Address_____
Employer's Address _____ Spouse's Work Phone_____
DOB_____Social Security No._____ Home Phone_____
Home Phone_____Work Phone_____ Spouse's Cell Phone_____
Cell Phone_____Email_____ DOB_____
Whom may we thank for this referral?_____ I will pay by:
Person responsible for this account_____ Cash ☐ Check ☐ Credit Card ☐
Drivers License No._____
In Case of Emergency Notify_____ Phone_____

**********Insurance Information**********

Primary Dental Insurance_____ Employer _____
Name of Insured_____Relationship_____ SS#/Contract No._____ GroupNo._____

Secondary Dental Insurance_____ Employer_____
Name of Insured_____Relationship_____ SS#/Contract No._____Group No._____

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Check all appropriate spaces:

Now	Past	No		Now	Past	No		Now	Past	No	
			Heart Murmur				Emphysema/Respiratory				Physical/Mental Restrictions
			Heart Surgery				Diabetes				Malignancies/Cancer
			Rheumatic Fever				Hypoglycemia				Radiation/Chemotherapy
			Pace Maker				ThyroidDisorders				Anemia/Leukemia
			Heart Disease				Kidney Disorders				Seizures, Fainting Spells
			High Blood Pressure				Hepatitis				Mononucleosis
			Low Blood Pressure				Jaundice				Tuberculosis(TB)
			Circulatory Problem				Glaucoma				Ulcer
			Stroke				Vision Loss				Measles/Mumps/C Pox
			Abnormal Bleeding				Hearing Loss				Exposure or Treated for HIV/AIDS
			Allergy to Anesthetics				Nervous Problems				Venereal Disease
			Allergy to Meds/Drugs				Psychiatric Care				Blood Transfusions
			Arthritis, Phys. Disab.				Frequent Headaches				Chronic Fatigue Syndrome
			Joint/bone Replacements				Jaw/Facial Pain				Pregnancy
			Asthma				Neck/Back Pain				Birth Control Pills, Hormones
			Tobacco Use_____years				Denture/Partial		/		Blood Pressure

Do you have any Latex Allergies? Yes___ No ___
Do you need to be pre-medicated for your dental appointments?_____Pharmacy_____
List all Allergies:_____
List all Medications:_____
_____
List hospitalizations or surgeries_____
Medical Doctor(s)_____
Dental Concern(s)_____
I understand that I am responsible for all services regardless of insurance coverage and agree to pay my bill in its entirety or understand that additional fees may apply otherwise.

SIGNATURE_____**Date**_____

_____Date_____ _____Date_____ _____Date_____ _____Date_____