Medical History Form

Patient Name:

Date of Birth:

Sex:

Emergency Contact _____

Emergency Contact Phone _____

Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis ..... Yes No

Persistent cough greater than a 3 week duration ..... Yes No

Cough that produces blood ..... Yes No

Been exposed to anyone with tuberculosis ..... Yes No

Medical History

Are you now under the care of a physician? ..... Yes No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? ..... Yes No

Has there been any change in your general health within the past year? ..... Yes No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... Yes No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... Yes No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Do you wear contact lenses? ..... Yes No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ..... Yes No

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began _____

Do you use controlled substances (drugs)? ..... Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? ..... Yes No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? ..... Yes No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant ..... Yes No

Number of weeks _____

Taking birth control pills or hormonal replacement? ..... Yes No

Nursing? ..... Yes No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics ..... Yes No

Aspirin ..... Yes No

Penicillin or other antibiotics ..... Yes No

Barbiturates, sedatives, or sleeping pills ..... Yes No

Sulfa drugs ..... Yes No

Codeine or other narcotics ..... Yes No

Metals ..... Yes No

Latex (rubber) ..... Yes No

Iodine ..... Yes No

Hay fever/seasonal ..... Yes No

Animals ..... Yes No

Food ..... Yes No

Other ..... Yes No

If Other, please specify:

_____

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve ..... Yes No

Previous infective endocarditis ..... Yes No

Damaged valves in transplanted heart ..... Yes No

Congenital heart disease (CHD) ..... Yes No

Unrepaired, cyanotic CHD ..... Yes No

Repaired (completely) in the last 6 months ..... Yes No

Repaired CHD with residual defects ..... Yes No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease ..... Yes No

Angina ..... Yes No

Arteriosclerosis ..... Yes No

Congestive heart failure ..... Yes No

Damaged heart valves ..... Yes No

Heart attack ..... Yes No

Heart murmur ..... Yes No

Low blood pressure ..... Yes No

High blood pressure ..... Yes No

Other congenital heart defects ..... Yes No

Mitral valve prolapse ..... Yes No

Pacemaker ..... Yes No

Rheumatic fever ..... Yes No

Rheumatic heart disease ..... Yes No

Abnormal bleeding ..... Yes No

Anemia ..... Yes No

Blood transfusion ..... Yes No

If yes, date _____

Hemophilia ..... Yes No

AIDS or HIV ..... Yes No

Arthritis ..... Yes No

Autoimmune disease ..... Yes No

Rheumatoid arthritis ..... Yes No

Systemic lupus erythematosus ..... Yes No

Asthma ..... Yes No

Bronchitis ..... Yes No

Emphysema ..... Yes No

Sinus trouble ..... Yes No

Tuberculosis ..... Yes No

Cancer/Chemotherapy/Radiation Treatment	Yes	No
Chest pain upon exertion	Yes	No
Chronic pain	Yes	No
Diabetes Type I or II	Yes	No
Eating disorder	Yes	No
Malnutrition	Yes	No
Gastrointestinal disease	Yes	No
G.E. Reflux/persistent heartburn	Yes	No
Thyroid problems	Yes	No
Stroke	Yes	No
Glaucoma	Yes	No
Hepatitis, jaundice or liver disease	Yes	No
Epilepsy	Yes	No
Fainting spells or seizures	Yes	No

Neurological disorders	Yes	No
If yes, please specify _____		
Sleep disorder	Yes	No
Mental health disorders	Yes	No
Specify _____		
Recurrent infections	Yes	No
Type of infection _____		
Kidney problems	Yes	No
Night sweats	Yes	No
Osteoporosis	Yes	No
Persistent swollen glands in neck	Yes	No
Severe headaches/migraines	Yes	No
Severe or rapid weight loss	Yes	No
Sexually transmitted disease	Yes	No
Excessive urination	Yes	No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	Yes	No
Name of physician or dentist making recommendation (include phone number) _____		
Do you have any disease, condition, or problem not listed above that you think I should know about?	Yes	No
Please explain _____		

_____

Signature of Patient/Legal Guardian

Patient Registration

Patient Name: _____
Last First Middle

Date Of Birth:_____/_____/_____ Age:_____ .SSN#_____-_____-_____

_____Male _____Female _____Single _____Married _____Divorced _____Widowed

Mailing Address:_____
Street City State Zip Code

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Occupation:_____ Employer:_____

Employer Address:_____
Street City State Zip Code

Do you have a Personal Physician? _____Yes _____No

Physician Name:_____ Phone #_____

Primary Insurance

Insurance Company Name
_____

Group Id#_____

Subscriber Name:_____

SSN#_____

Date of Birth:_____

Relation to Patient
_____Self _____Spouse _____Parent

Secondary Insurance

Insurance Company Name
_____

Group Id#_____

Subscriber Name:_____

SSN#_____

Date of Birth:_____

Relation to Patient
_____Self _____Spouse _____Parent

Authorization and Release

I authorize my Insurance Company to pay to Sequoia Dental Office all Insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all Insurance submissions. I understand and agree that I am financially responsible for all charges not covered by my Insurance Company.

_____ _____
Patient or Guardian Signature Date