Patient Name: _____ Patient Date of Birth: _____

| Insurance Name/Number: | Medical Ins | Primary Dental Insurance | Secondary Dental Insurance |
|---|---|---|---|
| **Personal Insurance or through Employer (Name)** | | | |
| **Subscriber Name/Relation** | | | |
| **Subscriber DOB** | | | |
| **Subscriber Social Sec. #** | | | |
| **Subscriber ID/Policy #** | | | |

Would you like us to bill medical first? (Medical sometimes covers Extraction of Impacted Wisdom Teeth)

**Medical Health History**

All past medical and dental history is important for your optimal care. Please take time to be accurate and thorough.

Current Dentist (Name, Number, Date of Last Visit): _____ _____ _____

Current Physician (Name, Number, Date of Last Visit): _____ _____ _____

Pharmacy (Name, Number, Street Name): _____ _____ _____

Weight & Height: _____ _____

Current Medications (Prescription, Non-Prescription, Supplements, Topical, Birth Control): _____

_____

Drug Allergies: _____

Previous Surgeries or Hospitalizations or Serious Illness: _____

_____

**Please Check All That Apply**

___ Allergies or Hay Fever
___ Arthritis or Rheumatism
___ Asthma
___ Cancer (Type & Year)
___ Child Birth
___ Clench or grind teeth
___ Colonoscopy
Alcoholic Beverages
___ Diabetes I or II
___ Dizziness, ringing, pain in ears
___ Drug Abuse (Previous or Current)
___ Epilepsy, convulsions, or seizure
___ Excessive fear of dental treatment
___ Fever blisters or mouth ulcers
___ Frequent headaches
___ Glaucoma
___ Heart trouble (murmur/mitral valve prolapse)
___ Heart Attack
___ High Blood Pressure
___ History of TMJ (jaw joint problems)
Kidney or bladder disease
___ Liver disease or Hepatitis
___ Lung disease (TB, emphysema, etc.)
___ Mouth breathing or excessive snoring
___ Previous oral surgery
___ Prosthetic devices (heart, valve, hip, etc.)
___ Pre Med Antibiotic
___ Pregnant
___ Psychiatric therapy or emotional problems
___ Sexually Transmitted Disease
___ Shortness of breath or swollen ankles
___ Sinus problems
Stroke
Subject to prolonged bleeding/bruise easily
___ Tenderness or stiffness in jaw/neck/back
___ Thyroid problems
___ Ulcers or stomach problems
___ Use tobacco products
___ Wear contact lenses

**The above Information is accurate and complete to the best of my knowledge.**

Patient or Parent/Guardian Signature: _____ Date: _____

Blood Pressure Day of Consult: _____ Doctor's Initials: _____