

MEDICAL HISTORY

To the best of your knowledge, are you or have you ever been afflicted with any of the following? ***Please answer yes or no:***

Heart ailment: _____

Prolonged bleeding: _____

Diabetes: _____

High Blood pressure: _____

Rheumatic Fever: _____

Respiratory Disease: _____

Epilepsy: _____

Hepatitis: _____

Healing Complications: _____

Prosthetic Joint: _____

Pacemaker: _____

HIV+: _____

Dry Mouth: _____

Please list medications you are allergic to: _____

Please list medications you are currently taking: _____

Name of Physician: _____ Physician's phone #: _____

DENTAL INSURANCE INFORMATION

Name of Insurance Co: _____ Phone #: _____

Name of Subscriber: _____ Subscriber's Birth Date: _____

Subscriber I.D./SS#: _____ Group #: _____

I understand that my insurance coverage is a contract between me and my insurance company. I am financially responsible for all charges whether or not paid for by insurance.

Patient Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____