Confidential Medical History

Please print and fill out form completely. Thank you.

date: _____ LTE ID #: _____

PATIENT INFORMATION

patient name (first, middle initial, last): _____

❑male ❑female social security #: _____

Is patient a minor? ❑yes ❑no *If yes, please provide parent/guardian name:* _____

MEDICAL HISTORY

name of physician: _____ phone: _____

date of last visit: _____ reason for last visit: _____

Your current physical health is? ❑good ❑fair ❑poor

Are you taking any medications? ❑yes ❑no *If yes, please list:* _____

_____

_____

Have you ever taken Phen-Fen, Redux, or Pondimin? ❑yes ❑no *If yes, when?* _____

Are you currently taking aspirin? ❑yes ❑no *Are you taking herbal supplements?* ❑yes ❑no

Are you pregnant? ❑yes ❑no week #_____ *Are you taking birth control pills?* ❑yes ❑no

Have you ever had any of the following diseases or medical problems?

AIDS	❑yes ❑no	drug abuse	❑yes ❑no	knee replacement	❑yes ❑no
alcohol abuse	❑yes ❑no	emphysema	❑yes ❑no	joint replacement	❑yes ❑no
anemia	❑yes ❑no	epilepsy	❑yes ❑no	liver disease	❑yes ❑no
arthritis	❑yes ❑no	fainting	❑yes ❑no	mitral valve prolapse	❑yes ❑no
asthma	❑yes ❑no	heart attack	❑yes ❑no	pacemaker	❑yes ❑no
bleeding problems	❑yes ❑no	heart murmur	❑yes ❑no	radiation treatment	❑yes ❑no
blood transfusion	❑yes ❑no	heart surgery	❑yes ❑no	rheumatic fever	❑yes ❑no
breathing problems	❑yes ❑no	heart valve replacement	❑yes ❑no	seizures	❑yes ❑no
cancer/chemotherapy	❑yes ❑no	hemophilia	❑yes ❑no	sinus problems	❑yes ❑no
colitis	❑yes ❑no	hepatitis	❑yes ❑no	steroid therapy	❑yes ❑no
congenital heart defect	❑yes ❑no	high blood pressure	❑yes ❑no	SBE (subacute bact endocarditis)	❑yes ❑no
defibrillator	❑yes ❑no	hip replacement	❑yes ❑no	thyroid treatment	❑yes ❑no
diabetes	❑yes ❑no	HIV	❑yes ❑no	ulcers	❑yes ❑no
dizzy spells	❑yes ❑no	kidney problems	❑yes ❑no	Other? please specify _____	❑yes ❑no

Is there any other medical condition you have that is not listed above?: _____

Have you had any recent hospitalizations?: _____

Are you allergic to any of the following?

aspirin	❑yes ❑no	local anesthesia	❑yes ❑no	penicillin	❑yes ❑no
codeine	❑yes ❑no	latex	❑yes ❑no	other antibiotics	❑yes ❑no

Please list any other drugs or materials that you are allergic to: _____

_____

1st update *Any changes?* _____ date: _____

patient/guardian signature: _____ reviewed by doctor: _____

Confidential Patient Information

Please print and fill out form completely. Thank you.

today's date: _____ LTE ID #: _____

Have you been pre-medicated? ❑yes ❑no

PATIENT INFORMATION

patient name (first, middle initial, last): _____

❑male ❑female social security #: _____ occupation: _____

street address: _____ apartment/floor #: _____

city: _____ prov: _____ pc: _____ birthdate: _____

home phone: _____ alternate phone: _____ email: _____

Whom may we thank for referring you? _____

What is your general dentist's name? _____

Person to contact in case of emergency: name: _____ phone: _____

Are you a student? ❑yes ❑no *If yes, please complete the following line:*

college / school name: _____ city: _____ prov: _____

Payment is expected at the time of treatment, and may be made by the following:

❑cash ❑personal check ❑Visa ❑MasterCard ❑American Express

DENTAL INSURANCE INFORMATION

name of insured: _____ relationship to patient: _____

birthdate: _____ social security #: _____

employer: _____ date employed: _____ work phone: _____

insurance company name: _____

group #: _____ policy / ID #: _____

insurance co address: _____ city: _____ prov: _____ pc: _____

Do you have additional dental insurance? ❑yes ❑no *If yes, please complete the following:*

name of insured: _____ relationship to patient: _____

birthdate: _____ social security #: _____

employer: _____ date employed: _____ work phone: _____

insurance company name: _____

group #: _____ policy / ID #: _____

insurance co address: _____ city: _____ prov: _____ pc: _____

PERSON RESPONSIBLE FOR PAYMENT

name of person responsible for payment: _____ relationship to patient: _____

street address: _____ apartment/floor #: _____

city: _____ prov: _____ pc: _____

home phone: _____ alternate phone: _____ email: _____

birthdate: _____ social security #: _____ driver's license #: _____

employer: _____ work phone: _____

patient signature: _____