Donald R McGee, DMD, PA

FAMILY & COSMETIC DENTISTRY

CONFIDENTIAL MEDICAL HISTORY

PATIENT INFORMATION

Patient Name _____ Preferred Name _____ Date of Birth _____

Home Phone _____ Work Phone _____ Cell Phone _____

Home Address _____

Street *City* *State* *Zip*

Social Security # _____ Patient's Employer _____

Business Address _____

Name of Spouse _____ Person Responsible for Account _____

Emergency Contact: Name _____ Phone _____

Referred By _____

E-Mail Address: _____ May we contact you by E-Mail? Y ☐ N ☐

Text Message? Y ☐ N ☐

INSURANCE INFORMATION

Dental Insurance Company _____ Group # _____

Insurance Company Address _____ Phone # _____

Insurance Policy Holder _____ Employed By _____

Policy Holder Date of Birth _____ Social Security # _____

Member Phone # _____ Member ID # _____

MEDICAL HISTORY

Are you currently under the care of a physician? ..... Y ☐ N ☐

If yes, what condition(s) are you being treated for? _____

Have you ever been hospitalized or had a major operation? ..... Y ☐ N ☐

Please list any medications (prescription or over-the-counter) you are currently taking _____

_____

_____

Do you use tobacco products? Y ☐ N ☐ If yes, how many packs/day or cans/day? _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa ☐ Iodine

☐ Other _____

If yes, please describe reaction _____

Do you currently have, or have you had in the past, any of the following conditions? (Check appropriate boxes below)

AIDS/HIV Positive	Y☐N☐	Convulsions/Epilepsy	Y☐N☐	Blood Pressure High / Low	Y☐N☐
Alzheimer's Disease	Y☐N☐	Diabetes	Y☐N☐	Irregular Heartbeat	Y☐N☐
Anemia	Y☐N☐	Easily Winded	Y☐N☐	Kidney Problems	Y☐N☐
Anxiety / Depression	Y☐N☐	Emphysema	Y☐N☐	Liver Disease	Y☐N☐
Arthritis/Gout	Y☐N☐	Excessive Bleeding	Y☐N☐	Osteoporosis	Y☐N☐
Artificial Heart Valve	Y☐N☐	Excessive Thirst	Y☐N☐	Pacemaker	Y☐N☐
Artificial Joint	Y☐N☐	Fainting Spells/Dizziness	Y☐N☐	Pain in Jaw Joints	Y☐N☐
Asthma	Y☐N☐	Frequent Cough	Y☐N☐	Psychiatric Care	Y☐N☐
Blood Thinners	Y☐N☐	Frequent Headaches	Y☐N☐	Rheumatic Fever	Y☐N☐
Breathing Problem	Y☐N☐	Glaucoma	Y☐N☐	Sexually Transmitted Disease STD	Y☐N☐
Bruise Easily	Y☐N☐	Hay Fever/Sinus Trouble	Y☐N☐	Shingles	Y☐N☐
Cancer or Tumors	Y☐N☐	Heart Murmur	Y☐N☐	Stomach/Intestinal Disease	Y☐N☐
Chest Pains	Y☐N☐	Heart Trouble/Disease	Y☐N☐	Stroke	Y☐N☐
Cold Sores/Fever Blisters/Ulcers	Y☐N☐	Hepatitis A, B, or C	Y☐N☐	Thyroid/Parathyroid Disease	Y☐N☐
				Tuberculosis	Y☐N☐

Do you have, or had in the past, any medical conditions not previously listed?..... Y☐N☐

If yes, please list _____

Chief Dental Complaint: _____

Does having your teeth cleaned make you nervous?..... Y☐N☐

Women only: Are you…

Pregnant or planning pregnancy? Y☐ N☐ Taking oral contraceptives? Y☐ N☐ Nursing? Y☐ N☐

CONSENT FOR TREATMENT:

I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetics or premedications that may be advised by the doctor. I understand that I will be responsible for any financial obligation for treatment on myself or the above named person. To the best of my knowledge, the questions on this form have been answered accurately. I understand that it is my responsibility to inform the dental office of any changes in my (or patient's) medical status.

Signature of Patient, Parent, or Guardian _____ Date _____

Signature of Dentist _____ Date _____