McGee Family 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 _____

E-Mail Address: _____ Referred By _____

May we contact you by E-mail? Y ❑ N ❑ Text Message? Y ❑ N ❑

Name of Spouse _____ Person Responsible for Account _____

Emergency Contact: Name _____ Phone _____

INSURANCE INFORMATION

Dental Insurance Company _____ Group # _____

Insurance Company Address _____ Phone # _____

Insurance Policy Holder _____ Employed By _____

Policy Holder Date of Birth _____ Member Phone # _____

Policyholder SSN _____ 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, had a major operation, or had an artificial joint replacement? . . . . . Y ❑ N ❑

Have you ever taken or been prescribed bisphosphonates (oral or IV), for osteoporosis or osteopenia? . . . . . Y ❑ N ❑

Have you ever been premedicated in the past for dental treatment? . . . . . Y ❑ N ❑

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfate ❑ Iodine

❑ Other _____

If yes, please describe reaction _____

Do you currently have, or have you had in the past, any of the following conditions?

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

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 ❑

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

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

_____

_____

_____

_____

_____

_____

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 _____

Health History Update – For Office Use Only

Date:	Date:
Date:	Date:
Date:	Date:
Date:	Date:
Date:	Date: