MEDICAL HISTORY AND PERTINENT INFORMATION - ADULT

PATIENT'S FULL NAME		PREFERRED NAME	
BIRTHDATE		SOCIAL SECURITY #	
HOME PHONE	WORK PHONE		CELL PHONE
ADDRESS			
EMPLOYER	ADDRESS		

SPOUSE'S NAME		PREFERRED NAME	
BIRTHDATE		SOCIAL SECURITY #	
SPOUSE'S EMPLOYER	ADDRESS		

PATIENT'S DENTAL INSURANCE		EMPLOYEE I. D. #	
GROUP #	CONTRACT OR POLICY #		INS. CO. PHONE #
FAMILY MEMBERS COVERED BY POLICY			

SPOUSE'S DENTAL INSURANCE		EMPLOYEE I. D. #	
GROUP #	CONTRACT OR POLICY #		INS. CO. PHONE #
FAMILY MEMBERS COVERED BY POLICY			

DENTAL HISTORY

FORMER DENTIST	LAST VISIT DATE

WHY DID YOU DECIDE TO CHANGE DENTISTS?

DO YOU HAVE PAIN, DISCOMFORT OR KNOWN PROBLEMS?

ARE YOU NERVOUS ABOUT DENTAL VISITS?

WHAT CHANGES WOULD YOU MAKE IN THE APPEARANCE OF YOUR TEETH?

MEDICAL HISTORY

DOCTOR'S NAME	PHONE # AND LOCATION

UNDER DOCTOR'S CARE NOW? (PLEASE EXPLAIN)

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL VISITS?	ARE YOU PREGNANT?

LIST ALLERGIES TO METALS, MATERIALS AND MEDICATIONS:

LIST MEDICATIONS YOU ARE PRESENTLY TAKING:

CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOU

HEART TROUBLE	SINUS PROBLEMS	ASTHMA	CANCER	AIDS
HIGH BLOOD PRESSURE	FAINTING	HIV POSITIVE	CHEMOTHERAPY	HYPOGLYCEMIA
LOW BLOOD PRESSURE	STROKE	EMPHYSYMA	ARTHRITIS/GOUT	DEPRESSION
HEART MURMUR	DIABETES	TUBERCULOSIS	RADIATION TREATMENT	PSYCHIATRIC CARE
CONGENITAL HEART DEFECT	LIVER DISDEASE	HEPATITIS A	THYROID DISEASE	DRUG ADDICTION
ARTIFICIAL HEART VALVE	LUNG DISEASE	HEPATITUS B	SCARLET FEVER	BLEEDING PROBLEMS
BLOOD DISORDER	GLAUCOMA	HEPATITUS C	JAW PAIN	BRUISE EASILY
PACEMAKER	VENEREAL DISEASE	ARTIFICIAL JOINT	FREQUENT HEADACHE	HEMOPHILIA
ANEMIA	COLD SORES	KIDNEY TROUBLE	SEIZURES	NERVOUSNESS
CHEST PAIN	RHEUMATIC FEVER	SINUS TROUBLE	SICKLE CELL ANEMIA	NONE OF THE ABOVE

OTHER MEDICAL CONDITONS:

TODAY'S DATE	PATIENT SIGNATURE	STAFF SIGNATURE

STAFF NOTES:

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY INSURANCE CLAIMS AND DO HEREBY AUTHORIZE DIRECT PAYMENT OF MY DENTAL BENEFITS TO DR. CABELL.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL COSTS OF DENTAL CARE. Signature_____

WHOM MAY WE THANK FOR RECOMMENDING OUR OFFICE?