Pure Simple Dental

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Patient Medical History

Patient Information

Patient's Name:_____ ☐Female ☐Male DOB:_____

Married☐ Single☐ Widow(er)☐ Email: _____

Home Address:_____

Home Phone:_____ Cell Phone: _____Work Phone:_____

I prefer to be contacted by: Home Ph.☐ Cell Ph.☐ Work Ph. ☐ Email☐ Text Msg.☐

Employer:_____ Other Family Seen By Us:_____

Previous Dentist:_____ Date Last Seen:_____

Guardian Information

Name: _____ Relationship to Patient: _____

Home Phone:_____ Cell Phone: _____Work Phone:_____

Medical/Emergency Information

Family Physician: _____ Last Visit Date: _____

In case of an emergency, is there someone who lives near you that we can contact?

Name: _____ Relationship to Patient: _____

Home Phone:_____ Cell Phone: _____Work Phone:_____

Dental Insurance Information

Would you like us to courtesy bill for you? Primary Dental Ins. Provider:_____

☐No ☐Yes Subscribers Social Security #:_____

If Yes – Credit Card Number for any balance after billing. Subscribers Name:_____

#_____ Exp_____ ZIP _____ Subscribers DOB:_____

How Did You Hear About Our Office

Who may we thank for referring you? _____

☐Friend/Family ☐Drive By ☐Website ☐ Insurance Co. Website ☐ Mailer ☐ Other_____

Current Medical Health

Currently my physical health is: ☐Good ☐Fair ☐Poor Are you currently under a physician's care? ☐Yes ☐ No

Conditions That Might Prevent You From Receiving Dental Treatment

☐Fear/Anxiety ☐Cost of Treatment ☐Missing Work ☐Unfavorable Dental Experience ☐ Other

Medical Prescriptions

Please list any prescriptions you are taking and the condition being treated:

Drug Name	Reason Taking

Allergies

Are you ALLERGIC to any of the following?

- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Dental Anesthetics
- ☐ Tetracycline
- ☐ Jewelry/Metal
- ☐ Erythromycin
- ☐ Latex
- ☐ Other: Please list any other drug allergies.

☐ I have NO allergies to any drugs or medication.

Women

Are you currently taking birth control pills? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No No. of Weeks_____

Nursing? ☐ Yes ☐ No

Misc.

Have you ever taken or been given Oral or IV Bisphosphonate drugs (i.e. Fosamax, Boniva, Actonel, Zometa or Aredia) ?

☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No # of Packs/day _____ How many years_____

Medical History

Please select any of the following medical problems that you have or have ever had:

☐ Abnormal Bleeding	☐ Drug/Alcohol Abuse	☐ Latex Sensitivity	☐ Heart Defect
☐ Anemia	☐ Emphysema	☐ Psychiatric Problems	☐ Heart Murmur
☐ Artificial Joints	☐ Epilepsy/Seizures	☐ Radiation Treatment	☐ Heart Pacemaker
☐ Asthma	☐ Fever Blisters/Herpes	☐ Shingles	☐ Heart Surgery
☐ Arthritis	☐ Frequent Headaches	☐ Sinus Problems	☐ Heart Trouble
☐ Blood Transfusion	☐ Hemophilia	☐ Stroke	☐ High/Low Blood Pressure
☐ Cancer/Tumors	☐ Hepatitis	☐ Tuberculosis (TB)	☐ Mitral Valve Prolapse
☐ Chemotherapy	☐ HIV+/AIDS	☐ Ulcers	☐ Rheumatic Fever
☐ Diabetes	☐ Hospitalization	☐ Venereal Disease	☐ Heart Attack
☐ Difficulty Breathing	☐ Kidney/Renal Problems	☐ Fibromyalgia	☐ Anxiety/Nervousness

Please list any other conditions:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent including the use of anesthetics and other medication as necessary.

Patient/ Guardian Signature: _____ Date:_____

Office Use Only:

I verbally reviewed the medical/dental information above with the patient named herein.

Dr. Initials:____ Date:_____ Hygiene Initials:____ Date:_____

Updated_____ Updated_____ Updated_____ Updated_____ Updated_____ Updated_____