MEDICAL HISTORY

Patient's name _____

If a child: List Favorite TV Show _____ Toy _____

A complete and thorough history is vital to proper care and safety. We thank you for your cooperation and patience in completing this form. All information is confidential.

PLEASE ANSWER EACH QUESTION

Physician's name _____ Phone # _____

	YES	NO
Have you been under the care of a physician during the past four years?	☐	☐
Have you been hospitalized? Please list _____	☐	☐
Are you now taking any prescribed medications or non-prescription drugs?	☐	☐
Please list: 1. _____ 2. _____		
Are you allergic to any drugs, medications (dental anesthetics, valium, demerol, penicillin, codeine, aspirin, etc.?)	☐	☐
Please list: _____		
Do you smoke or use tobacco products? Packs per day _____ for how many years _____	☐	☐
Do you use chewing tobacco? Cans per Wk. _____ years _____	☐	☐
Women - Are you now pregnant or are you breast feeding? How far along? _____	☐	☐

Do you now have, or have you ever had any of the following?:

	YES	NO		YES	NO		YES	NO
allergies	☐	☐	pacemaker	☐	☐	special diet	☐	☐
heart attack/failure	☐	☐	emphysema	☐	☐	hay fever	☐	☐
circulatory problems	☐	☐	asthma	☐	☐	thyroid condition	☐	☐
heart murmur	☐	☐	kidney disease	☐	☐	arthritis	☐	☐
low blood pressure	☐	☐	liver disease	☐	☐	artificial joint (hip, knee, etc.)	☐	☐
high blood pressure	☐	☐	hepatitis	☐	☐	herpes	☐	☐
excessive bleeding	☐	☐	jaundice	☐	☐	frequent headaches	☐	☐
anemia	☐	☐	sinus problems	☐	☐	fainting/dizziness	☐	☐
stroke	☐	☐	ulcers	☐	☐	nervous disorders	☐	☐
rheumatic fever	☐	☐	stomach problems	☐	☐	seizures/convulsions	☐	☐
cancer	☐	☐	diabetes	☐	☐	blood transfusion	☐	☐
tuberculosis	☐	☐	excess thirst/urination	☐	☐	alcoholism	☐	☐
breathing difficulty	☐	☐	glaucoma	☐	☐	drug addiction	☐	☐
chest pain	☐	☐	heart valve implant	☐	☐	HIV/AIDS	☐	☐
latex allergy	☐	☐	venereal disease	☐	☐		☐	☐

Please add anything from your physical or mental health history that you feel is important or is not covered above:

_____

The above information is complete, and my permission is given to discuss any portion of it with my physician:

_____ Date _____

signature of patient, or parent/guardian if minor

LISA A. SNIDER, D.M.D.

Marital Status _____

Patient's full name _____ Birthdate____/____/____

Mailing address _____ Home Ph # _____

_____ Work Ph # _____

ALL FAMILY MEMBERS Email_____ Cell Ph#_____

NAME	BIRTHDATE	NAME	BIRTHDATE

Previous dentist _____ Last treatment ____/____
NAME CITY MO. YR.

Reason for present visit _____

Whom may we thank for referring you to us? _____

PERSON RESPONSIBLE FOR ACCOUNT

_____
NAME ADDRESS CITY PH #

Soc. Sec. No. _____ Employer _____
(Give company name - if self-employed)

Years with employer _____ Work Ph # _____

CREDIT REFERENCE

Bank _____ Account # _____

EMERGENCY NOTIFICATION
(NOT LIVING AT THE ABOVE ADDRESS)

Name _____ Ph. # _____ Relationship _____

FOR PATIENTS WITH DENTAL INSURANCE

Insured person's name _____ Soc. Sec. No. _____

Insurance company _____ Group/Policy # _____

If a second dental insurance policy exists, please complete the following —

Insured person's name _____ Soc. Sec. No. _____

Insurance company _____ Group/Policy # _____

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies.

This release is solely for the purpose of facilitating the billing and reimbursement, directly to the doctor, of insurance benefits under which I am entitled.

Signed _____ Date _____