PARKHURST & BELISLE, DDS

PATIENT'S MEDICAL HISTORY

Name _____ Date _____

Reason for this visit: _____

Previous Dentist: _____ Date of last dental visit? _____ Date of last X-rays? _____

Physical Health: ☐ Good ☐ Fair ☐ Poor Are you currently under the care of a Physician? ☐ No ☐ Yes

If Yes, please explain: _____

FOR WOMEN: On Birth Control? ☐ No ☐ Yes Pregnant? ☐ No ☐ Yes Week # _____ Nursing? ☐ No ☐ Yes

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS: **(Check all that apply)**

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Diabetes (diet, pills, insulin)
- ☐ Difficulty Breathing
- ☐ Drug or Alcohol Abuse
- ☐ Dry Eyes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Heart Problems - of any kind *(surgery, murmurs, pacemaker, heart valve replacement, etc.)*
- ☐ Hepatitis A B C
- ☐ HIV
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Sinus or Nasal Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TMJ
- ☐ Tobacco Use
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Other _____
- ☐ None

Does your physician require you to take antibiotics before Dental Appointments? ☐ No ☐ Yes

Any History of Bacterial Endocarditis? _____

Please list any serious medical or surgical conditions, hospitalizations or previous injuries: _____

Please list **ALL** medications which you are taking, including ***NON-PRESCRIPTION*** or ***HERBAL*** medicine: _____

Circle if you have taken any of the following for osteoporosis: ◯ **Zometa** ◯ **Aredia** ◯ **Boniva** ◯ **Actonel** ◯ **Fosamax**

Are you ***allergic*** to any of the following:

- ☐ Any Metals
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Food (list) _____
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other _____
- ☐ None

Misc: _____

The information that I have provided on this form is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the doctor to perform any services deemed necessary during my diagnosis and treatment, with my informed consent.

_____ _____

Adult Patient Signature (Parent or Guardian) Date

_____

Doctor's Signature

Rev. 4/10

For Office Use ☐

PATIENT INFORMATION

DATE _____

Legal Name _____ (First Name) ____ (M.I) _____ (Last Name) Birth Date _____ Age _____ Male/Female

Preferred Name _____ Marital Status _____ Spouse's Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Cell Phone ( ) _____ Home Phone ( ) _____ Work Phone ( ) _____

Email: _____ Best way to confirm appointments: ☐ E-mail ☐ Phone

Employer _____ Driver's License # _____ State _____

Physician First Name _____ Last Name _____

Whom may we thank for referring you First Name _____ Last Name _____

Have you previously been seen/treated by any of our doctors? ☐ Yes ☐ No Approximate Date _____

Has anyone in your immediate family been seen in this office? _____ Name if different when last seen _____

Emergency Contact _____ Phone ( ) _____

If patient is a *minor* and/or *college student* covered under parent's insurance, please complete:

Name of School _____ City _____ ☐ Full time ☐ Part time

Parent/Legal Guardian First Name _____ Last Name _____ Date of Birth _____

Address _____ (Street) (City) (State) (Zip) SS# _____

INSURANCE INFORMATION

Primary Coverage: Dental

Insurance Co. Name _____

Insurance Co. Phone ( ) _____ Group # (Plan, Local or Policy #) _____

Insured's Name _____ (First Name) (Last Name) Birth Date _____ SS# _____

Relationship to Patient _____ Insured's Employer _____

Secondary Coverage: Dental

Insurance Co. Name _____

Insurance Co. Phone ( ) _____ Group # (Plan, Local or Policy #) _____

Insured's Name _____ (First Name) (Last Name) Birth Date _____ SS# _____

Relationship to Patient _____ Insured's Employer _____

BENEFIT ASSIGNMENT / AGREEMENT TO PAY

I hereby authorize my insurance company to make direct payment to the doctor. I understand that I am responsible for all costs of treatment. I further understand that the insurance coverage quoted at the time of service is only an ***estimate*** of Usual and Customary Charges and that, after the final insurance payment is made, **I will be responsible for the balance.**

_____ Signature of Adult Patient (Parent or Legal Guardian) _____ Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Parkhurst & Belisle, DDS, Family Dentistry to release medical information to the patient's insurance carrier and its designates.

_____ Signature of Adult Patient (Parent or Legal Guardian) _____ Date

PARKHURST & BELISLE, DDS
FAMILY DENTISTRY

PO25 Rev. 4/10