Medical History – Adult Patient

Date Created:

CROWLEY
DENTAL CARE

Patient Name: **Date of Birth:**

Email: **Phone Number:**

Who referred you to our office?

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions.

Are you under a physician's care now? Yes No

Do you have a primary care physician? Yes No

If yes, please list name and contact information:

Have you ever been hospitalized or had a major operation? Yes No
If yes, please explain:

Have you ever had a serious head or neck injury? Yes No

Are you taking any medications, pills, or drugs? Yes No

If yes, please list:

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Are you on a special diet? Yes No

If yes, please explain:

Do you use tobacco in any form? Yes No

How much?

For Female Patient: Are you...

Pregnant/Trying to get pregnant? Taking oral contraceptives?

Nursing?

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other Allergies? Yes No If yes, please list:

Do you have, or have you had any of the following? Please check **YES (Y)** or **NO (N)**.

	Y	N
AIDS/HIV Positive		
Alzheimer's Disease		
Anaphylaxis		
Anemia		
Angina		
Arthritis/Gout		
Artificial Heart Valve		
Artificial Joint		
Asthma		
Blood Disease		
Blood Transfusion		
Breathing Problems		
Bruise Easily		
Cancer		
Chemotherapy		
Chest Pains		
Cold Sores/Fever Blisters		

	Y	N
Congenital Heart Disorder		
Cortisone Medicine		
Diabetes		
Drug Addiction		
Easily Winded		
Emphysema		
Epilepsy or Seizures		
Excessive Bleeding		
Excessive Thirst		
Fainting Spells/Dizziness		
Frequent Diarrhea		
Frequent Headaches		
Glaucoma		
Hay Fever		
Heart Attack/Failure		
Heart Murmur		
Heart Pacemaker		

	Y	N
Hemophilia		
Hepatitis A, B or C		
Herpes		
High Blood Pressure		
High Cholesterol		
Hives or Rash		
Hypoglycemia		
Irregular Heartbeat		
Kidney Problems		
Leukemia		
Liver Disease		
Low Blood Pressure		
Lung Disease		
Mitral Valve Prolapse		
Osteoporosis		
Pain in Jaw Joints		
Radiation Treatments		

	Y	N
Recent Weight Loss		
Renal Dialysis		
Rheumatic Fever		
Rheumatism		
Scarlet Fever		
Shingles		
Sickle Cell Disease		
Sinus Trouble		
Spina Bifida		
Stomach/Intestinal Disease		
Stroke		
Swelling of Limbs		
Thyroid Disease		
Tuberculosis		
Tumors or Growths		
Ulcers		
Venereal Disease		

If yes, please explain:

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

Have you ever had any serious trouble associated with previous dental treatment? Yes No

Does dental treatment make you nervous? Yes No

Have you had a dental checkup or cleaning recently? Yes No

If yes, when?

Do you have or have you ever had any of the following?

Bleeding/Sore Gums	Yes	No
Orthodontic Treatment	Yes	No
Periodontal (Gum) Treatment	Yes	No
Clicking/Popping Jaw	Yes	No
Difficultly opening or closing jaw	Yes	No
Clenching or Grinding	Yes	No

New Patient Registration

CROWLEY
DENTAL CARE

First Name: **Middle Initial:**

Last Name: Patient Is: Policy Holder Responsible Party

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

Full Name: Email:

Address: Home: ( )

Work: ( )

City: State: Zip: Mobile: ( )

Birth Date: SSN:

I am: Policy holder for the patient Primary insurance policy holder Secondary insurance policy holder

PATIENT INFORMATION AGE MALE FEMALE

Address: Email:

Home: ( )

City: State: Zip: Work: ( )

Birth Date: SSN: Mobile: ( )

I would like to receive correspondences via email.

Employment: Full Time Part Time Retired **Student:** Full Time Part Time

Employer:

PRIMARY INSURANCE RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

Name of Insured:	Insurance ID: Insurance Group ID:
Insured Social Security:	Insured Birth Date:
Employer:	Insurance Company:
Address:	Address:
City: State: Zip:	City: State: Zip:
Employer Phone:	Insurance Phone:

SECONDARY INSURANCE RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

Name of Insured:	Insurance ID: Insurance Group ID:
Insured Soc. Sec:	Insured Birth Date:
Employer:	Insurance Company:
Address:	Address:
City: State: Zip:	City: State: Zip:
Employer Phone:	Insurance Phone: