Janet K. Song, DDS
FAMILY DENTAL CARE

Medical History and Patient Information Form

Last Name, First Name, Middle I.

Street Address

City, State, ZIP

Date of Birth **Social Security**

Sex **Marital Status**

Home Phone **Business Phone**

Occupation/ Employer

Business Address

Spouse's Name **Business Phone**

Person Responsible for this Account

Address **Phone**

Insured Person's Full Name

Relationship To Patient

Referral Source

Purpose for this Visit

INSURANCE INFORMATION

PRIMARY Insurance
Policy Number____
Group Plan Number____________________________________

SECONDARY Insurance
Policy Number____
Group Plan Number____________________________________

Teeth sensitivity? Cold | Hot | Sweets | Pressure (circle)

Do you prefer a local anesthetic for most dental treatments?	Y	N
Bleeding gums? For how long? __________________________		
Food impaction?	Y	N
Past or present use of chewing tobacco, cigarettes, pipes or cigars?	Y	N
How long? ____		
Swelling or lumps in the mouth?	Y	N
Frequent on blisters on lips or mouth?	Y	N
Pain around ear?	Y	N
Unusual sounds around ear while eating?	Y	N
Unpleasant taste?	Y	N
Mouth breathing?	Y	N
Gum (periodontal) diseases?	Y	N
Gum (periodontal) treatment?	Y	N
Do you use dental floss?	Y	N
Do you use a water jet device?	Y	N
Do you use an electric toothbrush?	Y	N
Do you use fluoride rinse?	Y	N
Do you bite your fingernails or cheeks?	Y	N
Do you brush twice a day?	Y	N
Do you like your smile?	Y	N
Are you under a physician's care?	Y	N

For what? ____

Date of last physical exam ____________________________

Are you in good health? _______________________________

Date of last dental exam **Date of last x-rays taken**

Physician's name and telephone number?

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Medication you are taking (include reason and dosage) ______________________________

Please explain hospitalization and/or serious illness ______________________________

Please explain any injuries to the face, head mouth or teeth ______________________________

Have you ever had an allergic or unusual reaction to any of the following medications?

Dental Anesthetics	Y	N
Codeine or other narcotics	Y	N
Penicillin	Y	N
Aspirin or Tylenol compounds	Y	N
Barbiturates or tranquilizers	Y	N
Erythromycin	Y	N

Any other drug or medication, please list:

____

Do you have any of the following:

Artificial heart valve or joints	Y	N
Heart pacemaker	Y	N
Heart trouble	Y	N
Mitral valve prolapse	Y	N
Herpes	Y	N
Hepatitis/jaundice/liver disease	Y	N
Blood transfusions	Y	N
Sexually transmitted disease	Y	N
HIV positive	Y	N
AIDS/Immunosuppressive disorders	Y	N
Cold sores	Y	N
Back problems	Y	N
Women, are you pregnant?	Y	N
Women, are you nursing?	Y	N
Women, are you taking birth control pills?	Y	N
Stomach diseases/ulcer	Y	N
Pulmonary (lung) disease	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N
Sinus Trouble	Y	N
Stroke	Y	N
High blood pressure	Y	N
Low blood pressure	Y	N
Thyroid disease	Y	N
Any blood disease	Y	N
Abnormal bleeding from a cut	Y	N
Latex allergy	Y	N
Arthritis	Y	N
Asthma	Y	N
Anemia	Y	N
Anorexia	Y	N
Diabetes	Y	N
Epilepsy	Y	N
Rheumatic fever	Y	N
Kidney disease	Y	N
Migraine headaches	Y	N
Cyst, growth, tumor, or cancer	Y	N
Glaucoma	Y	N
Alcohol/drug dependency	Y	N

Is there anything else we should know about your medical history?

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I acknowledge that the information provided on this Patient Medical History form is complete and correct. I understand that payment is expected when services are rendered. As a courtesy to you, we will submit claims to certain insurance companies. However, any outstanding balance will be your responsibility

Patient Signature:______________________________

Patient Email: ______________________________

Patient Cell Phone: ______________________________