



NEW PATIENT Medical History Form Page 1 of 2

ABOUT YOU	INSURANCE
Today's Date: _____	Primary Insurance
Email Address _____ Name _____ Prefer to be called _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Birthdate _____ Age: _____ Social Security # _____ DL # _____ Home Address _____ City _____ Zip _____ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____ Extension _____ Employer _____ Employer Address _____ City _____ Zip _____ How long there? _____ Occupation _____ Where & when are best times to reach you? _____ Whom may we thank for referring you? _____ Other family members seen by us? _____ Dentist _____ Person Responsible for Account _____	Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Co. _____ Address _____ City _____ State _____ Zip _____ Insurance Co. Phone (_____) _____ Group # (Plan, Local or Policy #) _____ Insured's Name _____ Relationship to Patient _____ Insured's Birthdate _____ ID # _____ Insured's Employer _____ Employer's Address _____ City _____ State _____ Zip _____
Spouse Information	Secondary Insurance
Spouse Name _____ Employer _____ Work Phone _____ Extension _____ Social Security Number _____ Birthdate _____ DL # _____ Relative or Friend not living with you: Name _____ Relation _____ Work Phone _____ Home Phone _____	Secondary Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Co. _____ Insurance Co. Address _____ City _____ State _____ Zip _____ Insurance Co. Phone (_____) _____ Group # (Plan, Local or Policy #) _____ Insured's Name _____ Relationship to Patient _____ Insured's Birthdate _____ ID # _____ Insured's Employer _____ Employer's Address _____ City _____ State _____ Zip _____
<div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;"> Payment is due in full at the time of treatment unless prior arrangements have been approved. </div> I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Dr. M. Forest Butler of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or exam rendered, to my insurance company.	
Signature _____ Date _____	



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MEDICAL HISTORY DENTAL HISTORY

Do you have a personal physician? Yes No
Physician's Name _____

Phone # (____) _____ Date of last visit? _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter drugs? Yes No

Please list: _____

Have you ever taken Fosamax or other bisphosphonate? Yes No

Have you ever taken Phen-Fen? Yes No

For Women:

Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week # _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- Y N Abnormal bleeding/hemophilia Y N Herpes / fever blisters
- Y N AIDS Y N High blood pressure
- Y N Alcohol / drug abuse Y N HIV
- Y N Anemia Y N Hospitalized for any reason
- Y N Arthritis Y N Kidney problems
- Y N Artificial bones / joints / valves Y N Liver disease
- Y N Asthma Y N Low blood pressure
- Y N Blood tranfusion Y N Lupus
- Y N Cancer / chemotherapy Y N Mitral valve prolapse
- Y N Colitis Y N Pacemaker
- Y N Congenital heart defect Y N Psychiatric problems
- Y N Diabetes Y N Radiation treatment
- Y N Difficulty breathing Y N Rheumatic / scarlet fever
- Y N Emphysema Y N Seizures
- Y N Epilepsy Y N Shingles
- Y N Fainting Spells Y N Sickle cell disease / traits
- Y N Frequent headaches Y N Sinus problems
- Y N Glaucoma Y N Stroke
- Y N Hay fever Y N Thyroid problems
- Y N Heart attack / surgery Y N Tuberculosis (TB)
- Y N Heart murmur Y N Ulcers
- Y N Hepatitis Y N Venereal disease

Please list any serious medical condition(s) you have experienced:

Are you allergic to any of the following?

- Y N Aspirin Y N Erythromycin Y N Penicillin
- Y N Codeine Y N Jewelry / metals Y N Tetracycline
- Y N Dental Anesthetics Y N Latex Y N Other

List any other drugs/materials you are allergic to: _____

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Your current dental health is: Good Fair Poor

Have you ever had a serious or difficult problem associated with any previous dental work? Yes No

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium Soft

Have you ever had gum treatment? Yes No

Do your gums ever bleed? Yes No Ever itch? Yes No

Have you ever had periodontal disease? Yes No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)? Yes No

Are your teeth sensitive to heat, cold, or anything else? Yes No

Do you have any loose teeth? Yes No

Do you still have wisdom teeth? Yes No

Would you like fresher breath? Yes No

Would you like whiter teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of Dr. M. Forest Butler of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____ Date _____

FOR OFFICE USE ONLY

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

Initials _____ Date _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If yes, please explain: _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

Has there been any change in your health status since your last visit? Y N
If yes, please explain: _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____