sky dental
FAMILY & COSMETIC DENTISTRY

MEDICAL HISTORY FORM

PATIENT INFORMATION

Name _____ (Last / First / Middle Initial) Social Security # ___ - ___ - ____ Sex ☐ M ☐ F

Date _____ Home Phone ( ) - Cell Phone ( ) - Age _____

Address _____ (Street / City / State / ZIP)

Email _____ Date of Birth _____ (Month / Day / Year)

(Check One) ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor ☐ Partnered for _____ Years

Your Occupation _____ Significant Other _____ (Last / First / Middle Initial)

Employer / School _____ Work Phone ( ) -

Preferred Contact Method (Check One) ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Emergency Contact _____ (Last / First / Middle Initial) Home Phone ( ) - Cell Phone ( ) -

REFERRAL INFORMATION – WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

(Check One) ☐ Another Patient ☐ Another Doctor ☐ Walk-In/Drive-by ☐ Google/Internet ☐ Sky Dental Website

Name of source referring you to our practice: _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last / First / Middle Initial) Social Security # ___ - ___ - ____

Relationship to Patient _____ Date of Birth _____

Address (if different than patient's) _____ (Street / City / State / ZIP)

Person Responsible Employed by _____ Employer Phone ( ) -

Employer Address _____ (Street / City / State / ZIP)

Insurance Company _____ Contract Number _____ Group Number _____

Subscriber Number _____ Number of other dependents Covered by this plan: _____

DENTAL HISTORY

Reason for Visit _____ Date of Last Dental Care Visit _____

Former Dentist _____ Date of Last Dental X-Rays _____

Address of Former Dentist _____ (City / State / ZIP)

Check (√) If you've had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Acid Reflux	☐ Sensitivity to Hot
☐ Bleeding Gums	☐ Loose Teeth or Broken Fillings	☐ Sensitivity to Sweets	☐ Clicking or Popping Jaw
☐ Periodontal Treatment	☐ Sensitivity When Biting	☐ Food Collection Between Teeth	☐ Sensitivity to Cold
☐ Sores or Growths in your Mouth			

How Often do you Brush your Teeth? _____ How often do you floss? _____

Please Complete Page 2

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If Yes, please describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If Yes, please give approximate dates: _____

(Women only) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (☑) If you have or have had any of the following:

- ☐ Anemia
- ☐ Angina
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical / Alcohol Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Problems
- ☐ Corn Allergy
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Immune System Problems
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Latex Allergy
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sulfite Allergy
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Problems
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List Medications you are currently taking: _____

_____

_____

Allergies (Environmental or Drug): _____

AUTHORIZATION

I acknowledge that: I am responsible for informing Sky Dental Dentists about any changes in my health history prior to treatment, and I accurately completed all information in this form, including the dental and medical history sections.

My health-care (dental and medical history) may be disclosed as necessary to my current Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below:

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

MEDICAL HISTORY UPDATE

DATE	MEDICAL UPDATE DESCRIPTION	PATIENT'S SIGNATURE	DOCTOR'S SIGNATURE
| |			
| |			
| |			
| |			
| |			
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| |			

Thank You and Welcome to Sky Dental!