Verde Dental Care

Patient Medical History Form

Patient's Last Name: _____ Mr. Dr. Mrs. Ms. Miss First _____ MI _____

Birthdate _____ Social Security # _____ Sex: Male _____ Female _____

Marital Status (Select one): ❑Married ❑Single ❑Other

Mailing Address:_____

Street Address City State Zip

Res. Tel. _____ Mobile Tel. _____ Email address: _____

How may we contact you? (Select all that apply): ❑Phone ❑Text ❑Email ❑Mail

If minor, parent/guardian name: _____ DOB: _____ SS#:_____

Have any of your family members been seen in this office?: _____

DENTAL INSURANCE INFORMATION (Please Present Card)

Primary Insurance Company: _____

Phone Number: _____ Subscriber Name: _____

Subscriber ID/SSN: _____ Subscriber DOB: _____

Employer: _____ Group Number: _____

Secondary Insurance Company:__ _____

Phone Number: _____ Subscriber Name: _____

Subscriber ID/SSN: _____ Subscriber DOB: _____

Employer: _____ Group Number: _____

Medical Insurance Company: _____

Phone Number: _____ Subscriber Name: _____

Subscriber ID/SSN: _____ Subscriber DOB:_____

Employer: _____ Group Number: _____

I hereby authorize the office of Verde Dental Care LLC/Eric A. Pettersen, DMD, and/or his agents to affix my name to any and all claims or documents as related to any and all health bernefits due me and/or my dependents. I hereby authorize payment of my dental benefits otherwise payable to me, to be paid directly to Verde Dental Car LLC/Eric A. Pettersen, DMD.

_____ _____

SUBSCRIBER SIGNATURE

I certify that all information I have provided on the entirety of this form is true and correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I hereby authorize Verde Dental Care LLC to release any information relating to my dental health care to other health care providers. I understand and agree that regardless of any amount my insurance company may or may not pay, I am ultimately responsible for all charges incurred, and for the balance on my account for any and all professional services rendered. In the event my account is turned over for collection, I understand that I will be responsible for all collection costs.

I will be paying by (select one): ❑Cash ❑Check ❑Credit/Debit Card ❑Care Credit

_____ _____

Signature of Patient or Parent/Guardian *Date*

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

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 have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. This information will become a part of your permanent dental file and will be considered CONFIDENTIAL. Thank you for answering the following questions.

Family Physician _____ Date of Last Physical: _____

Emergency Contact Name / Relationship _____ Tel. ( ) _____

Height _____ Weight _____ What is your estimation of your general health? ❑Good ❑Fair ❑Poor

Have you ever had surgery? ❑YES ❑NO If yes, please explain: _____

Have you ever had a serious head/neck injury? ❑YES ❑NO If yes, please explain: _____

Do you take/have you taken Phen-Fen or Redux? ❑YES ❑NO If yes, please explain: _____

Do you consider yourself a nervous person? ❑YES ❑NO If yes, please explain: _____

Are you on a special diet? ❑YES ❑NO If yes, please explain: _____

Do you smoke? ❑YES ❑NO If yes, how much: _____ per ❑DAY ❑WEEK Chew tobacco/snuff? _____

Do you use controlled substances? ❑YES ❑NO If yes, please explain: _____

Are you, or have you ever taken any Bisphosphonate drugs? (Including Fosamax, Actonel, Boniva, IV Zometa or Aredia)

❑YES ❑NO If yes, please explain: _____

Please list any medications/drugs you are taking (including strength and frequency if known): _____

_____

_____

Have you ever been told you need to **pre-medicate** for dental procedures? ❑YES ❑NO If yes, for what condition? _____

Are you allergic or have you ever had a reaction to any of the following:

Aspirin	❑YES ❑NO	Sleeping Pills	❑YES ❑NO
Penicillin	❑YES ❑NO	Dental Anesthetics (Novicaine)	❑YES ❑NO
Codeine	❑YES ❑NO	Latex	❑YES ❑NO
Acrylic	❑YES ❑NO	Metal(s)	❑YES ❑NO
Foods	❑YES ❑NO	If yes, please specify:	
Other drugs	❑YES ❑NO	If yes, please specify:	

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

AIDS/HIV Positive	❑YES ❑NO		❑YES ❑NO	Hormone Therapy	❑YES ❑NO	Rheumatic Fever	❑YES ❑NO
Allergies	❑YES ❑NO	Diabetes	❑YES ❑NO	Hemophilia	❑YES ❑NO	Rheumatism	❑YES ❑NO
Alzheimer's Disease	❑YES ❑NO	Drug / Alcohol Dependency		Hepatitis A	❑YES ❑NO	Scarlet Fever	❑YES ❑NO
Anaphylaxis	❑YES ❑NO		❑YES ❑NO	Hepatitis B or C	❑YES ❑NO	STDs	❑YES ❑NO
Anemia	❑YES ❑NO	Emphysema	❑YES ❑NO	High Blood Pressure	❑YES ❑NO	Shingles	❑YES ❑NO
Arthritis	❑YES ❑NO	Epilepsy or Seizures	❑YES ❑NO	Hives or Rash	❑YES ❑NO	Sickle Cell Disease	❑YES ❑NO
Artificial Heart Valve	❑YES ❑NO	Fainting Spells/Dizziness		Hypoglycemia	❑YES ❑NO	Sinus Trouble	❑YES ❑NO
Artificial Joint	❑YES ❑NO		❑YES ❑NO	Irregular Heartbeat	❑YES ❑NO	Spina Bifida	❑YES ❑NO
Bleeding Problems	❑YES ❑NO	Frequent Cough	❑YES ❑NO	Kidney Problems	❑YES ❑NO	Stomach/Intestinal Disease	
Blood Transfusion	❑YES ❑NO	Frequent Diarrhea	❑YES ❑NO	Leukemia	❑YES ❑NO		❑YES ❑NO
Breathing Problems	❑YES ❑NO	Frequent Headaches	❑YES ❑NO	Liver Disease	❑YES ❑NO	Stroke	❑YES ❑NO
Bruise Easily	❑YES ❑NO	Genital Herpes	❑YES ❑NO	Low Blood Pressure	❑YES ❑NO	Swelling of Limbs	❑YES ❑NO
Cancer	❑YES ❑NO	Glaucoma	❑YES ❑NO	Lung Disease	❑YES ❑NO	Thyroid Disease	❑YES ❑NO
Chemotherapy	❑YES ❑NO	Gout	❑YES ❑NO	Mitral Valve Prolapse	❑YES ❑NO	Tonsillitis	❑YES ❑NO
Chest Pains	❑YES ❑NO	Hay Fever	❑YES ❑NO	Pain in Jaw Joints	❑YES ❑NO	Tuberculosis	❑YES ❑NO
Cold Sores / Fever Blisters		Heart Attack / Failure	❑YES ❑NO	Parathyroid Disease	❑YES ❑NO	Tumors or Growths	❑YES ❑NO
	❑YES ❑NO	Heart Murmur	❑YES ❑NO	Psychiatric Care	❑YES ❑NO	Ulcers	❑YES ❑NO
Congenital Heart Disorder		Heart Pace Maker	❑YES ❑NO	Radiation Treatments	❑YES ❑NO	Yellow Jaundice	❑YES ❑NO
	❑YES ❑NO	Heart Trouble / Disease		Recent Weight Loss	❑YES ❑NO		
Cortisone Medicine / Steroids			❑YES ❑NO	Renal Dialysis	❑YES ❑NO		

WOMEN, *Are you...*

Pregnant/Trying to get pregnant? ❑YES ❑NO Taking Oral Contraceptives? ❑YES ❑NO Nursing? ❑YES ❑NO

Have you had any serious illness not listed above? ❑YES ❑NO *If yes, please explain:* _____

_____, have received and have read a copy of this office's Notice of Privacy Practices.

(Print Name)

Signature of patient, parent or guardian: _____ **Date:** _____