Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Mailing Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Pharmacy Name _____ Phone _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Mailing Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

DUO DENTAL
GROUP

Medical History Form

- Are you in dental discomfort today? ☐Yes ☐No
  If so, what would you like us to do? _____
- Are you happy with your smile? ☐Yes ☐No
- Do you wish your teeth were whiter? ☐Yes ☐No
- Do you wish your teeth were straighter? ☐Yes ☐No
- Do you wish to have your missing teeth replaced, if you have any? ☐Yes ☐No
- Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Yes ☐No
- If yes, please describe: _____
- Is there any dental treatment you are interested in? ☐Yes ☐No
  If yes, please describe: _____

Please answer the following questions regarding your <u>previous dentist</u>:
Former Dentist: _____ Phone: _____
Address: _____
Date of last dental care: _____

Please answer the following questions regarding your <u>physician</u>:
Are you currently under physician care? ☐Yes ☐No
If yes, please describe: _____
Physician's Name: _____ Phone: _____
Address: _____
Date of last medical visit: _____

- Have you had any serious illnesses or operations? ☐Yes ☐No
  If yes, please describe:
  _____
- Have you had a blood transfusion? ☐Yes ☐No
  If yes, give approximate dates:
  _____
- Have you ever taken Fen-Phen? Redux? ☐Yes ☐No
- Have you ever used a bisphosphonate medication for osteoporosis? (Brand names include but not limited to: Fosamax, Actonel, Atelvia, Didronel, Boniva) ☐Yes ☐No
- Do you smoke or use other tobacco/smokeless products? ☐Yes ☐No
- If yes, please circle all that apply: Cigarettes, Cigars, Vape, Marijuana, Chew, Other:
- Women: Are you pregnant or possibly pregnant? ☐Yes ☐No
  Nursing? ☐Yes ☐No
  Taking birth control pills? ☐Yes ☐No

Please continue on the backside →

Please check if you have had any of the following:

- ☐ AIDS/HIV positive
- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems/ surgeries Describe:_____
- ☐ Hemophilia/ abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Rapid weight gain or loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/ scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease
- ☐ Tobacco habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal disease

❖ Are you taking any medications? If yes, list all:

_____

_____

❖ Do you have any allergies? If yes, list all:

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and helpful dental treatment. If there is any change in my medical status, I will inform the staff and dentist at Duo Dental Group.
I authorize Duo Dental Group to release all information necessary to secure the payment of benefits from my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_____ Date: _____