GENERAL INFORMATION AND MEDICAL HISTORY FORM

Name_____ **SS#**_ _ _-_ _ -_ _ _
Street Address_____**Town/St/Zip**_____
Home Phone _ _ _-_ _ _-_ _ _ _ **Work**_ _ _ -_ _ _ -_ _ _ _
Cell _ _ _-_ _ _-_ _ _ _ **DOB**_ _/_ _ /_ _ _ _ **Age**_____
Employer_____**Occupation**_____
Sex M / F Marital Status _____
Responsible Party _____
Primary Dental Insurance Company _____
Name of Insured _____**Relationship** _____
SS# of member _ _ _-_ _-_ _ _ _ **DOB**_ _-_ _-_ _ _ _
We will make copies of your insurance cards.

Medical History

MD Name_____ **MD Phone #** _ _ _-_ _ _ -_ _ _ _

Place a check next to those conditions which you have.

Heart disease___**Heart Attack**___**Heart Valve Problems**___**Heart Surgery**___
High Blood Pressure___**Stroke**___**Angina**_____
Lung Disease (TB, Pneumonia,COPD, etc)___**Neurologic Disease(Seizures)**___
Psychiatric Meds___**Diabetes**___**Asthma/Sinusitis**___**Kidney Disease**_____
Liver Disease___**Stomach/Intestinal Disease**___**Cancer**___**Artificial Joints**_____
Arthritis___**Infectious Disease(VD, Staph)**___**Chemical Dependency**_____
Jaw Pain___**Cold Sores/Canker Sores**___ **Other**_____
Operations___**explain**

Please list all medications you are taking_____

_____

Are you allergic or have you had any adverse reactions to any medications (penicillin, aspirin, codeine, latex, etc.)? _____
Explain_____

Signature_____**Date** _ _-_ _-_ _ _ _