Shelton DENTAL CENTER

Health History -Patient Information

Name_____
Last First Middle

Address_____

City_____State_____Zip_____Email_____

Phone(_____)_____(_____)_____(_____)_____
Home Cell Work

Social Security #_____ Birthday_____ Male❑ Female❑

Emergency Contact_____relationship_____

How did you hear about us?_____

Primary Dental Insurance

Subscriber Name: _____ Relationship to Patient: _____

Social Security Number: _____ DOB: _____

Subscriber ID Number: _____ Group ID Number: _____

Employer Name: _____ Insurance Co. Phone: _____

Insurance Co. Name/Address: _____

Secondary Dental Insurance

Subscriber Name: _____ Relationship to Patient: _____

Social Security Number: _____ DOB: _____

Subscriber ID Number: _____ Group ID Number: _____

Employer Name: _____ Insurance Co. Phone: _____

Insurance Co. Name/Address: _____

Medical Insurance

Subscriber Name: _____ Relationship to Patient: _____

Social Security Number: _____ DOB: _____

Subscribers Address: _____

Subscriber ID Number: _____ Group ID Number: _____

Employer Name: _____ Insurance Co. Phone: _____

Employer Address: _____

Insurance Co. Name/Address: _____

Shelton DENTAL CENTER

Medical History

Conditions:

- ❑Abnormal bleeding
- ❑Alcohol or Drug Abuse
- ❑Aids/HIV
- ❑Allergies
- ❑Anemia
- ❑Angina
- ❑Asthma
- ❑Blood transfusions
- ❑Cancer/chemotherapy
- ❑Diabetes
- ❑Difficulty Breathing
- ❑Emphysema
- ❑Epilepsy
- ❑Fever Blisters/Herpes
- ❑Heart Attack
  Date_____
- ❑Heart Murmur/Defect
- ❑Heart Surgery
- ❑Hemophilia/bleeding
- ❑Hepatitis Type_____
- ❑Blood Pressure: hi/low
- ❑Joint Replacement:
  Date_____
- ❑Kidney Problems
- ❑Liver Disease
- ❑Pacemaker
- ❑Psychiatric Disease
- ❑Radiation therapy
- ❑Rheumatic Fever
- ❑Seizures
- ❑STD
- ❑Shingles
- ❑Sickle Cell Disease
- ❑Sinus Problems
- ❑Stroke
- ❑Thyroid problems
- ❑Tuberculosis
- ❑Ulcers
- ❑Other_____

Allergies to:

- ❑Aspirin
- ❑Codeine
- ❑Anesthetics
- ❑Latex
- ❑Metals/Jewelry/Nickel
- ❑Penicillin
- ❑Sulfa
- ❑Tetracycline
- ❑Other_____

Miscellaneous:

Do you smoke?
yes❑ no❑

Do you chew?
yes❑ no❑

If Female:

Are you taking Birth Control Pills?
yes❑ no❑

Are you Pregnant?
yes❑ no❑

Medications and Dosage:

_____

_____

_____

Name of Current Physician: Phone Number:

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance carriers and assign directly to Shelton Dental Center, all insurance benefits, if any, otherwise payable directly to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. The information on this page and the medical history are correct to the best of my knowledge.

Responsible Party_____ Relation to patient_____

Signature_____ Date_____