West Hartford DENTAL GROUP

Patient Information/Medical History

Please Print

Patient Name _____ **Date of Birth** ___/___/___ **Age** ____ **Marital Status**: S__ M__ D__ W__

Mailing Address _____ **Town**_____ **Zip Code**_____

HOME phone number_____ **CELL/MOBILE phone number** _____

Email Address _____ **Appt confirmation preference**: phone call____ text____ email____

Parent Name (first and last) if patient is a child _____

Who may we thank for referring you to West Hartford Dental Group?_____

Dental Insurance Information (please present insurance card to front desk staff)

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Subscriber Social Security Number_____-_____-_____

Insurance Carrier Name _____ **Insurance phone number**_____

Insurance Address _____

Insurance ID#_____ **Payer ID#**_____ **Group #**_____

Name of person responsible for payment_____**Employer phone number** _____

Medical History: PHYSICIAN'S NAME_____ DATE OF LAST PHYSICAL EXAM_____

PREVIOUS DENTIST NAME_____ DATE OF LAST THOROUGH DENTAL EXAM_____

ANSWER ALL QUESTIONS (Check YES or NO)

Y___ N___ Angina Pectoris	Y___ N___ Circulatory Problems	Y___ N___ Hepatitis
Y___ N___ Heart Murmur	Y___ N___ Stroke	Y___ N___ Rheumatic Fever
Y___ N___ Heart Problems	Y___ N___ Sinus Problem	Y___ N___ AIDS
Y___ N___ High Blood Pressure	Y___ N___ Asthma	Y___ N___ STDs
Y___ N___ High Cholesterol	Y___ N___ Diabetes	Y___ N___ Kidney Disease
Y___ N___ Microvalve Prolapse	Y___ N___ Jaundice	Y___ N___ Arthritis
Y___ N___ Nervous Problems	Y___ N___ Scarlet Fever	Y___ N___ Artificial Valves
Y___ N___ Psychiatric Treatment	Y___ N___ Tonsillitis	Y___ N___ Artificial Bones/Joints
Y___ N___ Malignancies	Y___ N___ Tuberculosis	Y___ N___ Cancer
Y___ N___ Epilepsy	Y___ N___ Ulcer	
Y___ N___ Mononucleosis	Y___ N___ Excessive Bleeding	

Are You Allergic to any of the following?

Y___ N___ Penicillin	Y___ N___ Codeine	List any other allergies:
Y___ N___ Aspirin	Y___ N___ Latex	_____
Y___ N___ Erythromycin	Y___ N___ Anesthetics	_____
Y___ N___ Tetracycline		_____

Are you pregnant?_____ Have you been hospitalized or had surgery in the last 12 months? _____

Have you ever been told that you should be pre-medicated for medical or dental appointments?_____

Are you taking any medication?_____ If yes, what and dosage?_____

--Office Use Only—

I have reviewed the Medical/Dental information above with the patient herein.

_____ _____

(**Doctor Signature**) (Date)

Doctor's Notes: