GREEN DENTAL
GENERAL & COSMETIC

Patient Medical History Form

ABOUT YOU

Today's Date:

Email Address _____

Name _____

Prefer to be called _____ ☐ Male ☐ Female

Birthdate _____ Age: _____

Social Security # _____ DL # _____

Home Address _____

City _____ Zip _____

☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Extension _____

Employer _____

Employer Address _____

City _____ Zip _____

Occupation _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Person Responsible for Account ☐ Self ☐ Other _____

Emergency Contact Information

Contact Name _____

Relation _____

Contact Phone _____

INSURANCE

Primary Insurance

Dental Coverage ☐ Yes ☐ No

Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Insurance Co. Phone (_____) _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate _____ ID # _____

Insured's Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Secondary Insurance

Secondary Dental Coverage ☐ Yes ☐ No

Insurance Co. _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone (_____) _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate _____ ID # _____

Insured's Employer _____

Employer's Address _____

City _____ State _____ Zip _____

OFFICE FINANCIAL POLICY

Full payment or co-payment is due at the time of treatment unless prior arrangements have been approved.

PPO Insurance: I understand that I am responsible for payment of dental services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I understand that the office will assist in obaining the maximum benefit by processing my insurance claim as a courtesy for me. I hereby authorize release of any information, including the diagnosis and records of treatment or exam rendered, to my insurance company. I hereby authorize payment directly to Dr. Maridette Cunanan of the group insurance benefits otherwise payable to me. I understand that the estimates of payment are subject to final approval by my insurance company and could therefore change the amount due to the office. Any underpayment from the insurance is my responsibility.

Signature _____ **Date** _____

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MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name _____
Phone # (____) _____ Date of last visit? _____
Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**
Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No
Have you had any metal rods, pins or implants? ☐ Yes ☐ No
Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No
Please list: _____

Have you ever taken Fosamax or other bisphosphonate? ☐ Yes ☐ No
Have you ever taken Phen-Fen? ☐ Yes ☐ No

For Women:
Are you using a prescribed method of birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week # _____
Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal bleeding/hemophilia	Y	N	Herpes / fever blisters
Y	N	AIDS	Y	N	High blood pressure
Y	N	Alcohol / drug abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for any reason
Y	N	Arthritis	Y	N	Kidney problems
Y	N	Artificial bones / joints / valves	Y	N	Liver disease
Y	N	Asthma	Y	N	Low blood pressure
Y	N	Blood tranfusion	Y	N	Lupus
Y	N	Cancer / chemotherapy	Y	N	Mitral valve prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital heart defect	Y	N	Psychiatric problems
Y	N	Diabetes	Y	N	Radiation treatment
Y	N	Difficulty breathing	Y	N	Rheumatic / scarlet fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle cell disease / traits
Y	N	Frequent headaches	Y	N	Sinus problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay fever	Y	N	Thyroid problems
Y	N	Heart attack / surgery	Y	N	Tuberculosis (TB)
Y	N	Heart murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal disease

Please list any serious medical condition(s) you have experienced:

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry / metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

List any other drugs/materials you are allergic to: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? ☐ Yes ☐ No
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Your current dental health is: ☐ **Good** ☐ **Fair** ☐ **Poor**
Have you ever had a serious or difficult problem associated with any previous dental work? ☐ Yes ☐ No
Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No
Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft
Have you ever had gum treatment? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No
Are your teeth sensitive to heat, cold, or anything else? ☐ Yes ☐ No
Do you have any loose teeth? ☐ Yes ☐ No
Do you still have wisdom teeth? ☐ Yes ☐ No
Would you like fresher breath? ☐ Yes ☐ No
Would you like whiter teeth? ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No
If not, what would you change? _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of **Dr. M. Cunanan** of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____ Date _____

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials _____ Date _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If yes, please explain:

Patient Signature _____ Date _____
Dentist Signature _____ Date _____

Has there been any change in your health status since your last visit? Y N
If yes, please explain:

Patient Signature _____ Date _____
Dentist Signature _____ Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.