PRAIRIE PARK DENTAL

Medical History Form

How did you find out about our office_____

Patient Information

Last name_____ First name_____MI___Preferred name_____
Date of birth - - SSN - - Male/Female (circle one)
Address_____Apt #_____City_____State_____Zip_____
Home phone_____Work phone _____Cell phone_____

Head of Household

Last name_____First name_____MI___Preferred name_____
Date of birth - - SSN - - Male/Female (circle one)
Employer_____Work phone_____
Email address for appointment reminders_____
Spouse_____Date of birth - - SSN - -

(If different from above)

Address_____Apt #_____City_____State_____Zip_____
Home phone_____Work phone _____Cell phone_____

Emergency Contact

Name_____Phone_____Relationship_____

Insurance Information

Name of insured_____Has the insured been a patient here? YES/NO
Insurance Company_____Group #_____ID#_____
Address_____City_____State____Zip_____Phone _____

As a condition of treatment of the above listed patient, I understand that financial arrangements must be made in advance. Charges incurred for treatment of the above listed patient are my responsibility and are due at the time services are rendered. A 24 hour notice of appointment cancellation is required to avoid an office visit fee.

Insurance Filing

I understand that the Practice will submit insurance claims for me and I agree to pay an estimated portion computed by Practice personnel on the date services are rendered. I authorize the Practice to release information regarding my treatment for the purposes of filing for potential payment of insurance benefits and I further grant assignment of any such proceeds of benefits to the Practice. Any remaining outstanding balance not paid within 60 days of date ofservice (the "waiting period") will then be subject to finance charges.

Finance Charges

I agree to pay a finance charge computed as 1.5% per month on any outstanding balance existing beyond the "waiting period".

Signature_____Date - - Relationship to patient_____

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Patient's Health History

Anemia	YES	NO	Heart Murmur	YES	NO	Rheumatic Fever	YES	NO
Arthritis	YES	NO	Hepatitis	YES	NO	Rheumatism	YES	NO
Artificial Joints	YES	NO	High Blood Pressure	YES	NO	Sinus Problems	YES	NO
Asthma	YES	NO	HIV	YES	NO	Stomach Problems	YES	NO
Blood Disease	YES	NO	Immune Sys Disorders	YES	NO	Stroke	YES	NO
Cancer	YES	NO	Jaundice	YES	NO	Tuberculosis	YES	NO
Diabetes	YES	NO	Kidney Disease	YES	NO	Tumors	YES	NO
Dizziness	YES	NO	Liver Disease	YES	NO	Ulcers	YES	NO
Epilepsy	YES	NO	Mental Disorders	YES	NO	Venereal Disease	YES	NO
Excessive Bleeding	YES	NO	Mitral Valve Prolapsed	YES	NO	Codeine Allergy	YES	NO
Fainting	YES	NO	Nervous Disorders	YES	NO	Latex Allergy	YES	NO
Glaucoma	YES	NO	Pacemaker	YES	NO	Penicillin Allergy	YES	NO
Growths	YES	NO	Pregnant	YES	NO	Other Allergies	YES	NO
Hay Fever	YES	NO	Pre-Medication	YES	NO			
Head Injuries	YES	NO	Radiation Treatment	YES	NO			
Heart Disease	YES	NO	Respiratory Problems	YES	NO			

1. Are you under medical care at this time? (list below)_____ Yes No
2. Have you been hospitalized during the last 5 years?_____ Yes No
3. Are you taking any medications at this time? (list below)_____ Yes No
4. Are there any dental concerns/problems? (list below)_____ Yes No
5. Teeth sensitive to hot/cold or sweet/sour. (please circle)
6. Have you had orthodontic treatment? Present/Past (please circle)
7. Do you clench or grind teeth?_____ Yes No
8. Have you had prolonged bleeding after surgery/lacerations?_____ Yes No
9. Do you frequently have a bad taste in your mouth?_____ Yes No
10. Do you frequently have a dry mouth?_____ Yes No
11. Do you smoke or chew tobacco?_____ Yes No
12. When was the last time you had a professional dental cleaning?_____
13. Other medical or dental concerns past or present?

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