MEDICAL ALERT office use only

NORWICH DENTAL

patient INFORMATION

Welcome to our office!!

Date: _____
M / D / Y

PATIENT INFORMATION

To assist the dentist and ensure your well being while undergoing treatment in our office please answer the following questions in detail. Information will be considered confidential and for our records only.
PLEASE PRINT NEATLY. **IF YOU HAVE QUESTIONS OR DESIRE ASSISTANCE PLEASE ASK RECEPTIONIST**

ADULT INFORMATION

❍ Dr. ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Miss

Name: _____ Date of Birth: _____
last first initial M / D / Y

Address: _____ Age: _____ Sex: _____
Street

_____ Marital Status: _____
city prov postal code

Home Phone: _____ Business Phone: _____ email: _____

Family Physician: _____ Phone: _____ Drivers License# _____

Medical Specialist 1: _____ Phone: _____

Medical Specialist 2: _____ Phone: _____

CHILD INFORMATION

Name: _____ Prefers to be called: _____
last first initial

Address: _____ Date of Birth: _____
Street M / D / Y

_____ Age: _____ Sex: _____
city prov postal code

Family Physician: _____ Phone: _____ Drivers License# _____

Medical Specialist: _____ Phone: _____

School: _____ Grade: _____

If the child's name and/or address is different than yours, or if you are the child's guardian, please complete the adult registration also.

PERSON RESPONSIBLE FOR ACCOUNT

❍ Self ❍ Other Name: _____

Address: _____ Phone: _____
Street

_____ Email _____
city prov postal code

Drivers License# _____

Employed by: _____ Phone: _____

Spouse employed by: _____ Phone: _____

DENTAL INSURANCE ❍ Yes ❍ No Group Policy No: _____ Certificate No: _____

Insurance Company Name: _____

Amount of coverage: Basic_____% Prosthetics_____% Crown/Bridge_____% Ortho_____% Perio Scaling_____%

Secondary Insurance: _____ Group Policy No: _____ Certificate No: _____

Amount of coverage: Basic_____% Prosthetics_____% Crown/Bridge_____% Ortho_____% Perio Scaling_____%

IN CASE OF EMERGENCY

Please Notify: _____

Relationship: _____ Phone: _____

Any other member of your family or relative a patient of this office? Name: _____

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MEDICAL HISTORY

Present Physician Name: _____ Phone: _____

Specialist Physician Name: _____ Phone: _____

Are you presently under Doctor's care? Why? _____ ○ Yes ○ No

Have you been under Doctor's care in the past two years? _____ ○ Yes ○ No

Have you taken any medications, pills or drugs in the past two years? _____ ○ Yes ○ No

Are you presently taking any medications, pills or drugs? If so what? _____ ○ Yes ○ No

Have you been hospitalized inthe past two year? If so why? _____ ○ Yes ○ No

When was your last complete physical exam? _____ ○ Yes ○ No

When walking, do you ever have to stop because of pain in your chest or shortness of breath? _____ ○ Yes ○ No

Have you ever had any type of surgery? What and when? _____ ○ Yes ○ No

Have you ever been diagnosed as having a tumor or cancer? _____ ○ Yes ○ No

Have you ever taken cortisone/steroid medication? _____ ○ Yes ○ No

Do you wish to speak privately with the Doctor about any problems? _____ ○ Yes ○ No

Has any family member had any medical conditions? _____ ○ Yes ○ No

Do you experience problems with healing? ____ ○ Yes ○ No Do you smoke? How much? _____ ○ Yes ○ No

Are you on a prescription diet? _____ ○ Yes ○ No Are you currently in good health? _____ ○ Yes ○ No

ALLERGIES

Please check off any medication you are allergic to or have reacted adversely to:

○ Nembutal	○ Ibuprofen (Advil)	○ Codine	○ Penicillin	○ Clindamycin	○ Cedhalexin	○ Local Anesthetic (Freezing)
○ Asprin	○ Seconal	○ Demerol	○ Amoxicillin	○ Scopolamkne	○ Sulfa Drugs	○ Nitrous Oxide
○ Tylenol	○ Naproxen	○ Percodan	○ Ampicillin	○ Tetracycline	○ Metal	○ Valium
○ Tylenol #1, #2, #3	○ Toradol	○ Darvon	○ Erythromycin	○ Rovamycin	○ Latex	○ Chlorhexidene (Peridex)

○ Food Allergies (please list) _____

Please list any other medications or substances which you know you are allergic to: _____

MEDICAL CONDITIONS

Please check off any of the following conditions you presently have or have had:

○ Heart Failure	○ Abnormal Bleeding	○ Tattoos	○ Transdermal Nicotine Patches	○ Bleeding Problems
○ High Blood Pressure	○ Chest Pain	○ Asthma	○ Cancer	○ Blood Transfusion
○ Low Blood Pressure	○ Angina Pectoris	○ Hay Fever	○ Thyroid Disease	○ Hemophilia
○ Heart Murmur	○ Shortness of Breath	○ Sinus Trouble	○ X-Ray or Cobalt Tmt	○ AIDS (HIV Positive)
○ Rheumatic Fever	○ Selling of Feet/Ankles/Hands	○ Emphysema	○ Chemotherapy/Radiation	○ Venereal Disease
○ Scarlet Fever	○ Fainting or Dizziness	○ Frequent Cough	○ Arthritis/Gout	○ Cold Sores
○ Congenital Heart Lesion	○ Stroke	○ Lung Disease	○ Rheumatism	○ Fever Blisters
○ Artificial Heart Valve	○ Diabetes or Hypoglycemia	○ Bronchitis	○ Pain in Jaw Joints	○ Herpes
○ Heart Pacemaker	○ Artificial Joints/Hips	○ Tuberculosis	○ Cortisone/Steroids	○ Bruise Easily
○ Heart Surgery	○ Kidney Trouble	○ Liver Disease	○ Glaucoma	○ Sickle Cell Anemia
○ Anemia	○ Ulcers	○ Hepatitis A (infec.)	○ Epilepsy or Seizures	○ Blood Disorders
○ Mitral Valve Prolapse	○ Allergies	○ Hepatitis B (serum)	○ Glandular Disorders	○ Circulation Problems
○ Cardiac Arrest/Heart Attack	○ Cosmetic Surgery	○ Hepatitis C	○ Mental/Nervous Disorders	○ Head/Neck Injuries
○ Hypertension	○ Malignant Hyperthermia	○ Yellow Jaundice	○ Psychiatric Care	○ Stomach/Intestinal Problems

○ Drug or alcohol addiction, if yes, have you received treatment? _____

Please list in detail any serious illness not shown above which you have or may have had: _____

WOMEN ONLY Are you pregnant? ○ Yes ○ No Due Date: _____ Are you taking birth control? ○ Yes ○ No

CHILD PATIENT ONLY ○ Measles ○ Mumps ○ Chicken Pox ○ Strep Throat ○ Tonsillitis ○ German Measles **Aprox Date:** _____

MEDICAL UPDATES

NOTE: it is important to notify our office of any chnage in your medical status.

Since my last visit, my Medical History as noted on this chart (has or has not) changed

DATE	HEALTH CHANGE	DETAILS	PATIENT SIGNATURE	REVEIWED BY
	○ Yes ○ No			
	○ Yes ○ No			
	○ Yes ○ No			