Patient Information and Medical History

Patient Name:_________________________________ Social Security Number:____________________________

Date of Birth:_________________________________ Gender:__________ Phone: _______________________

Address: ____ Email:_____________________________________

City: ____ State: ___________ Zip: _________________________

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Referred by: ________________________ Emergency Contact Name & Phone: _______________________________

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Parent or guardian (if under 18): ____________________________________ Phone: ________________________

Address: ____ SSN: _________________________

Employer: ____ Date of Birth: ___________________

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Spouse: ____ Phone: ________________________

Address: ____ SSN: _________________________

Employer: ____ Date of Birth: ___________________

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Please answer each of the following:

1. Date of last physical examination ______________________ Physicians name: _________________________

2. Have you been under the care of the physician in the past two years? ❏ No ❏ Yes, _______________________

3. Have you been hospitalized during the last two years? ❏ No ❏ Yes, _______________________

4. Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? ❏ No ❏ Yes, _______________________

5. Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by any foods or any other non medicinal items? ❏ No ❏ Yes, _______________________

6. Have you been out of the country in the past six (6) months? ❏ No ❏ Yes, _______________________

7. Have you had any contact with anyone who has been out of the country in the last six (6) months? ❏ No ❏ Yes, _______________________

Women:

8. Are you pregnant? ❏ No ❏ Yes Are you nursing? ❏ No ❏ Yes Are you taking birth control pills? ❏ No ❏ Yes
   Weeks __________

9. Check any of the following you have **had** or **have at present**:

❏ Heart Failure	❏ Heart Disease	❏ Angina Pectoris	❏ High Blood Pressure
❏ *Mitral Valve Prolaspe	❏ *Any type of Transplant	❏ *Rheumatic Fever	❏ *Autism
❏ Heart Pace Maker	❏ *Heart Murmur	❏ Angina	❏ Cancer __________
❏ Stroke	❏ Heart Surgery	❏ Psychiatric Treatment	❏ ADD/ADHD
❏ Kidney Disorder	❏ Seizures/Epilepsy	❏ Diabetes	❏ Emphysema
❏ Tuberculosis (TB)	❏ Ulcers	❏ Sinus Problems	❏ Hay Fever
❏ Bruise Easily	❏ Asthma	❏ Radiation Treatment	❏ Chemotherapy
❏ Jaundice	❏ Allergies or Hives	❏ Fainting/Dizzy Spells	❏ Sickle Cell Disease
❏ Thyroid condition	❏ Arthritis	❏ HIV Positive, ARC, AIDS	❏ Alcoholism
❏ Drug addiction	❏ Glaucoma	❏ Cortisone Medications	❏ Hepatitis _________
❏ Liver Disease	❏ Cold Sores	❏ Blood Transfusion	❏ Bleeding Disorder
❏ Herpes	❏ *Any type of Implant	❏ Use of Tobacco Products	❏ Spina Bifida
❏ *Congenital Heart Defect	❏ Heart Attack Date ____________	❏ Developmental Delays	❏ *Artificial knee, hip or other joint
❏ Alzhiemers/Dementia	❏ Down Syndrome	❏ Parkinson's Disease	❏ Oral or IV Bisphosphonates

* Antibiotic premedication may be required prior to your appointment

10. Are there any other health concerns we should be aware of?

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11. Please list all medications that you are currently taking (including over the counter medications, vitamins, or herbal remedies:

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Dental Insurance Information:

Name of Insurance Company : ____ Phone: _________________________

Subscriber's Name: __________________________ SSN: ____________________ Date of Birth: ____________________

Secondary Insurance Company: ____ Phone: _________________________

Subscriber's Name: __________________________ SSN: ____________________ Date of Birth: ____________________

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Financial Responsibility: ❏ Self ❏ Other - Please complete information below

Name of Responsible Party : ____ Phone: _________________________

Relationship to Patient: ______________________ SSN: ____________________ Date of Birth: ____________________

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BELTRAMI, DIXON, WOODARD, DDS PLC (DBA COMMONWEALTH DENTISTRY) FINANCIAL POLICY REQUIRES PAYMENT AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. Should my treatment be extensive, I may request additional information regarding financial plans. In the event that any balance on my account must be placed for collection, I agree to pay the collection agency fees up to 32%, reasonable attorney's fees, and all court costs. I understand that all amounts over 30 days after treatment are subject to finance charge of 1.5% per month (18% annual rate) I am aware that should I fail to keep an appointment without giving 24 hour notice, I will be charged a broken appointment fee.

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Patient (or Guardians) Signature Today's Date