

Verde Dental Care, LLC

Patient Medical History Form

Patient's Last Name: _____ Mr. Dr. Mrs. Ms. Miss First _____ MI _____

Birthdate _____ Social Security # _____ Sex: Male _____ Female _____

Marital Status (Select one): Married Single Other

If minor, parent/guardian name: _____ Birthday: _____

Social Security # _____ Sex: Male _____ Female _____

Mailing Address: _____
Street Address _____ City _____ State _____ Zip _____

Res. Tel. _____ Mobile Tel. _____ Email address: _____

How may we contact you? (Select all that apply): Phone Text Email Mail

Have any of your family members been seen in this office?: _____

DENTAL INSURANCE INFORMATION (Please Present Card)

Primary Insurance Company: _____

Phone Number: _____ Subscriber Name: _____

Subscriber ID/SSN: _____ Subscriber DOB: _____

Employer: _____ Group Number: _____

Secondary Insurance Company: _____

Phone Number: _____ Subscriber Name: _____

Subscriber ID/SSN: _____ Subscriber DOB: _____

Employer: _____ Group Number: _____

I hereby authorize the office of Verde Dental Care LLC/Eric A. Pettersen, DMD, and/or his agents to affix my name to any and all claims or documents as related to any and all health benefits due me and/or my dependents. I hereby authorize payment of my dental benefits otherwise payable to me, to be paid directly to Verde Dental Care LLC/Eric A. Pettersen, DMD.

SUBSCRIBER SIGNATURE

I certify that all information I have provided on the entirety of this form is true and correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I hereby authorize Verde Dental Care LLC to release any information relating to my dental health care to other health care providers. I understand and agree that regardless of any amount my insurance company may or may not pay, I am ultimately responsible for all charges incurred, and for the balance on my account for any and all professional services rendered. In the event my account is turned over for collection, I understand that I will be responsible for all collection costs.

I will be paying by (select one): Cash Check Credit/Debit Card Care Credit

Signature of Patient or Parent/Guardian

Date

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. This information will become a part of your permanent dental file and will be considered **CONFIDENTIAL**. Thank you for answering the following questions.

Family Physician _____ Date of Last Physical: _____

Emergency Contact Name / Relationship _____ Tel. () _____

Height _____ Weight _____ What is your estimation of your general health? Good Fair Poor

Have you ever had surgery? YES NO If yes, please explain: _____

Have you ever had a serious head/neck injury? YES NO If yes, please explain: _____

Do you take/have you taken Phen-Fen or Redux? YES NO If yes, please explain: _____

Do you consider yourself a nervous person? YES NO If yes, please explain: _____

Are you on a special diet? YES NO If yes, please explain: _____

Do you smoke? YES NO If yes, how much: _____ per DAY WEEK Chew tobacco/snuff? _____

Do you use controlled substances? YES NO If yes, please explain: _____

Are you, or have you ever taken any Bisphosphonate drugs? (Including Fosamax, Actonel, Boniva, IV Zometa or Aredia)
 YES NO If yes, please explain: _____

Please list any medications/drugs you are taking (including strength and frequency if known): _____

Have you ever been told you need to pre-medicate for dental procedures? YES NO If yes, for what condition? _____

Are you allergic or have you ever had a reaction to any of the following:

Aspirin	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sleeping Pills	<input type="checkbox"/> YES <input type="checkbox"/> NO
Penicillin	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dental Anesthetics (Novocaine)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Codeine	<input type="checkbox"/> YES <input type="checkbox"/> NO	Latex	<input type="checkbox"/> YES <input type="checkbox"/> NO
Acrylic	<input type="checkbox"/> YES <input type="checkbox"/> NO	Metal(s)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Foods	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please specify: _____	
Other drugs	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please specify: _____	

Do you have, or have you ever had, any of the following?

AIDS/HIV Positive <input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia <input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatism <input type="checkbox"/> YES <input type="checkbox"/> NO
Alzheimer's Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Drug / Alcohol Dependency <input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis A <input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever <input type="checkbox"/> YES <input type="checkbox"/> NO
Anaphylaxis <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis B or C <input type="checkbox"/> YES <input type="checkbox"/> NO	STDs <input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO	Emphysema <input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO	Shingles <input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy or Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO	Hives or Rash <input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell Disease <input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Heart Valve <input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting Spells/Dizziness <input type="checkbox"/> YES <input type="checkbox"/> NO	Hypoglycemia <input type="checkbox"/> YES <input type="checkbox"/> NO	Sinus Trouble <input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Joint <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Irregular Heartbeat <input type="checkbox"/> YES <input type="checkbox"/> NO	Spina Bifida <input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Cough <input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	Stomach/Intestinal Disease <input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Transfusion <input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Diarrhea <input type="checkbox"/> YES <input type="checkbox"/> NO	Leukemia <input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO
Breathing Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Headaches <input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Swelling of Limbs <input type="checkbox"/> YES <input type="checkbox"/> NO
Bruise Easily <input type="checkbox"/> YES <input type="checkbox"/> NO	Genital Herpes <input type="checkbox"/> YES <input type="checkbox"/> NO	Low Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disease <input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma <input type="checkbox"/> YES <input type="checkbox"/> NO	Lung Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Tonsillitis <input type="checkbox"/> YES <input type="checkbox"/> NO
Chemotherapy <input type="checkbox"/> YES <input type="checkbox"/> NO	Gout <input type="checkbox"/> YES <input type="checkbox"/> NO	Mitral Valve Prolapse <input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO
Chest Pains <input type="checkbox"/> YES <input type="checkbox"/> NO	Hay Fever <input type="checkbox"/> YES <input type="checkbox"/> NO	Pain in Jaw Joints <input type="checkbox"/> YES <input type="checkbox"/> NO	Tumors or Growths <input type="checkbox"/> YES <input type="checkbox"/> NO
Cold Sores / Fever Blisters <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Attack / Failure <input type="checkbox"/> YES <input type="checkbox"/> NO	Parathyroid Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO
Congenital Heart Disorder <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur <input type="checkbox"/> YES <input type="checkbox"/> NO	Psychiatric Care <input type="checkbox"/> YES <input type="checkbox"/> NO	Yellow Jaundice <input type="checkbox"/> YES <input type="checkbox"/> NO
Corticisone Medicine / Steroids <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Pace Maker <input type="checkbox"/> YES <input type="checkbox"/> NO	Radiation Treatments <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Heart Trouble / Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Recent Weight Loss <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Hormone Therapy <input type="checkbox"/> YES <input type="checkbox"/> NO	Renal Dialysis <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Rheumatic Fever <input type="checkbox"/> YES <input type="checkbox"/> NO	

WOMEN, Are you...

Pregnant/Trying to get pregnant? YES NO Taking Oral Contraceptives? YES NO Nursing? YES NO

Have you had any serious illness not listed above? YES NO If yes, please explain: _____

I, _____, have received and have read a copy of this office's Notice of Privacy Practices.

(Print Name)

Signature of patient, parent or guardian: _____ **Date:** _____