MEDICAL HISTORY

Although dental personnel primarily treat the area in & around your mouth, your mouth is part of your entire body. Health problems that you have, or medications that you are taking, could have an important interrelationship with dental treatment.

Are you under the care of a physician? [ ] Yes [ ] No If yes, please explain: _____

Have you been hospitalized or had a major operation [ ] Yes [ ] No If yes, please explain: _____

_____

Have you ever had serious head or neck injury? [ ] Yes [ ] No If yes, please explain: _____

_____

Are you taking any prescription or over-the-counter medications (this includes any vitamins or supplements)? [ ] Yes [ ] No If yes, please list: _____

_____

_____

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

[ ] HIV+/AIDS
[ ] ALZHEIMER'S DISEASE
[ ] ANAPHYLAXIS
[ ] ANEMIA
[ ] ANGINA
[ ] ARTIFICIAL BONES/JOINTS
[ ] ARTIFICIAL VALVES
[ ] ASPLENISM (ABSENCE OF SPLEEN)
[ ] ASTHMA/BREATHING PROBLEMS
[ ] ARTHRITIS
[ ] AUTOIMMUNE DISEASES
[ ] BLOOD DISEASE
[ ] BLOOD TRANSFUSION
[ ] BRUISE EASILY
[ ] CALCIFIED AORTIC STENOSIS
[ ] CANCER
[ ] CARDIAC TRANSPLANT (PROBLEMS W/ TRANSPLANTED HEART VALVES)
[ ]CHEMOTHERAPY
[ ] HEART ATTACK/FAILURE
[ ] HEART DISEASE
[ ] HEART MURMUR
[ ] HEART PACEMAKER
[ ] CHEST PAINS
[ ] COLD SORES/FEVER BLISTERS
[ ] CONGENITAL HEART DEFECT
[ ] CONVULSIONS
[ ] COLITIS
[ ] CORTISONE MEDICINE
[ ] DEMENTIA
[ ] DIABETES
[ ] DRUG ADDICTION
[ ] EMPHYSEMA
[ ] ENDOCARDITIS (INFECTION OF HEART CHAMBERS/VALVES)
[ ] EPILEPSY OR SEIZURES
[ ] EXCESSIVE THIRST
[ ] FREQUENT HEADACHES
[ ] GLAUCOMA
[ ] HEART SURGERY
[ ] HEMOPHILIA
[ ] HEPITITIS A
[ ] HEPITITIS B OR C
[ ]HIGH BLOOD PRESSURE
[ ] HYPOGLYCEMIA
[ ] IMMUNOSUPPRESSION
[ ] INDWELLING CATHETERS
[ ] IRREGULAR HEARTBEAT
[ ] KIDNEY PROBLEMS
[ ] LEUKEMIA
[ ] LIVER DISEASE
[ ] LOW BLOOD PRESSURE
[ ] LUNG DISEASE
[ ] MITRAL VALVE PROLAPSE
[ ] NONVASCULAR SHUNTS
[ ] ORGAN TRANSPLANT, STEM CELL & MARROW TRANSPLANTS
[ ] PAIN IN JAW JOINTS/TMJ
[ ] PSYCHIATRIC CARE
[ ] RADIATION TREATMENTS
[ ] RECENT WEIGHT LOSS
[ ] RENAL DIALYSIS
[ ] RHEUMATIC FEVER
[ ] SCARLET FEVER
[ ] SHINGLES
[ ] SICKLE CELL DISEASE
[ ] SINUS TROUBLE
[ ] SPINA BIFIDA
[ ] STOMACH/INTESINAL DISEASE
[ ] STROKE
[ ] SWELLING OF LIMBS
[ ] SYSTEMIC LUPUS ERTHEMATOSUS
[ ] THYROID DISEASE
[ ] TONSILITIS
[ ] TUBERCULOSIS
[ ] TUMORS OR GROWTHS
[ ] ULCERS
[ ] VENEREAL DISEASE
[ ] YELLOW JAUNDICE

Is there anything else medically we should be aware of before treatment? _____

I certify that I have read or understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Print Name: _____

Signature: _____ Date: _____

C.R. "Chip" Edwards, Jr., D.D.S.  *FAMILY & COSMETIC DENTISTRY*

WELCOME TO OUR FAMILY!!

We complete these services: Implants, crowns, bridges, partials, dentures, non-surgical gum treatment, preventative care, root canals, extractions, white-colored fillings, bleaching (among other treatment.) We begin seeing patients at age 3. The benefits of a happy, healthy smile are Immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

About You: *Today's Date:*_____ []Male []Female **AND** []Single []Married []Divorced []Widowed [ ] Separated

Name (LAST, FIRST) _____ **I prefer to be called:** _____ **DOB:** _____ **Social Security #:** _____

Mailing Address: _____ **Physical Address (if different from mailing):** _____

_____ _____

Home #: _____ **Work #:** _____ **Pager/Other#:** _____ **E-mail:** _____

How and when would you like to be contacted during the day? _____

Employer: _____ **Employers Address:** _____

How long there? _____ **Occupation:** _____

Who may we thank for referring you? (If not referred by a person, how did you hear about us.) _____

Other family members seen by us?: (PLEASE LIST NAMES) _____

Previous/Present Dentist: _____ **Last Visit Date:** _____ **What did you see the dentist for?:** _____

Spouse Information:

Their Name: _____ **Employer:** _____ **Work#:** _____

Social: _____ **DOB:** _____

Dental Insurance :

PRIMARY

Insurance Co. Name: _____ **Group #:** _____

Insurance Co Address: _____

_____ **Ins Co. Phone #:** _____

Insured's Name: _____ **Relation to Insured:** _____

Insured's DOB: _____ **Insured's Social:** _____

SECONDARY

Insurance Co. Name: _____ **Group #:** _____

Insurance Co. Address: _____

_____ **Ins. Co. Phone#:** _____

Insured's Name: _____ **Relation to Insured:** _____

Insured's DOB: _____ **Insured's Social:** _____

Emergency Contact: **(Someone we can contact that does not live with you):**

Name: _____ **Home #:** _____ **Work #:** _____ **Cell #:** _____