MEDICAL HISTORY

URIBE
FAMILY & COSMETIC DENTISTRY

PATIENT NAME :_____ Birth Date:_____

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 may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank for your answers

Are you under a physician's care now?	OYes ONo	If yes, please explain:_____
Have you ever been hospitalized or had a major operation?	OYes ONo	If yes, please explain:_____
Have you ever had a serious head or neck injury?	OYes ONo	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	OYes ONo	If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	OYes ONo	_____
Have you ever taken Fosamax, Bonivia, Actonel,Bisphosphonates	OYes ONo	_____
Are you on a special diet?	OYes ONo	_____
Do you use tobacco?	OYes ONo	
Do you use controlled substances?	OYes ONo	

Women: Are you

Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? : O Yes O No

Are you allergic to any of the following

Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa drugs O

O Other: If yes, please explain:_____

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

AIDS/HIV Positive	OYes ONo	Cortisone Medicine	OYes ONo	Hemophilia	O Yes ONo	Radiation Treatments	OYes ONo
Alzheimer's Disease	OYes ONo	Diabetes	OYes ONo	Hepatitis A	O Yes ONo	Recent Weight Loss	OYes ONo
Anaphylaxis	OYes ONo	Drug Addiction	OYes ONo	Hepatitis B or C	O Yes ONo	Renal Dialysis	OYes ONo
Anemia	OYes ONo	Easily Winded	OYes ONo	Herpes	O Yes ONo	Rheumatic Fever	OYes ONo
Angina	OYes ONo	Emphysema	OYes ONo	High Blood Preassure	O Yes ONo	Rheumatism	OYes ONo
Arthritis/ Gout	OYes ONo	Epilepsy or Seizures	OYes ONo	High Cholesterol	O Yes ONo	Scarlet Fever	OYes ONo
Artificial Heart Valve	OYes ONo	Excessive Bleeding	OYes ONo	Hives or Rash	O Yes ONo	Shingles	OYes ONo
Artificial Joint	OYes ONo	Excessive Thirst	OYes ONo	Hypoglycemia	O Yes ONo	Sickel Cell Disease	OYes ONo
Asthma	OYes ONo	Fainting Spells/Dizziness	OYes ONo	Irregular Heartbeat	O Yes ONo	Sinus Trouble	OYes ONo
Blood Disease	OYes ONo	Frequent Cough	OYes ONo	Kidney Problems	O Yes ONo	Spina Bifida	OYes ONo
Blood Transfusion	OYes ONo	Frequent Diarrehea	OYes ONo	Leukemia	O Yes ONo	Stomach/Intestinal Disease	OYes ONo
Breathing Problem	OYes ONo	Frequent Headaches	OYes ONo	Liver Disease	O Yes ONo	Stroke	OYes ONo
Bruise Easily	OYes ONo	Genital Herpes	OYes ONo	Low Blood Preassure	O Yes ONo	Swelling of Limbs	OYes ONo
Cancer	OYes ONo	Glaucoma	OYes ONo	Lung Disease	O Yes ONo	Thyroid Disease	OYes ONo
Chemotherapy	OYes ONo	Hey Fever	OYes ONo	Mitral Valve Prolapse	O Yes ONo	Tonsillitis	OYes ONo
Chest Pains	OYes ONo	Heart Attack/Failure	OYes ONo	Osteoporosis	O Yes ONo	Tuberculosis	OYes ONo
Cold Sore/Fever Blister	OYes ONo	Heart Murmur	OYes ONo	Pain in Jaw Joints	O Yes ONo	Tumors or Growths	OYes ONo
Congenital heart Disorder	OYes ONo	Heart Pacemaker	OYes ONo	Parathyroid Disease	O Yes ONo	Ulcers	OYes ONo
Convulsions	OYes ONo	Heart trouble/Disease	OYes ONo	Psychiatric Care	O Yes ONo	Venereal Desease	OYes ONo
				Bacterial Endocarditis	O Yes ONo	Yellow Jaundice	OYes ONo

Have you ever had any serous illness not listed above? O Yes O No _____

Comments: _____

To the best of my knowledge, the questions on this form have been acurately answered. I understrand that providing incorrect information can b dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or gUARDIAN: _____ DATE: _____

URIBE
FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION

Patient Name: _____ Date _____ Male / Female
Last First MI

___Married ___Single ___Child Birth Date ___-___-_____ Social Security # _____-_____-_____
M D Y

Address _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Whom may we thank for referring you to our practice? _____

DENTAL INSURANCE

Name of policy holder:_____

Member ID #: _____ Group #: _____

Employers Address: _____Employer:_____
Street

_____ _____ _____
City State Zip Code

Insurance Company: _____

Insurance Company Address: _____
Street

_____ _____ _____
City State Zip Code

RESPONSABLE PARTY INFORMATION

The following is for the person responsible for payment: ____ Self ____Spouse ____ Parent or Guardian

Name: _____ Employer:_____
Last First MI

Birth Date ___-___-_____ Social Security # _____-_____-_____
M D Y

Phone (Home):_____ Work:_____Ext:_____ Cell:_____

E-mail_____ Fax:_____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Driver's License # _____ State:_____