Patient Information & Medical History Form

CitiPlace Dental & Hygiene

Title_____ First Name_____Surname_____

Date of Birth_____ Marital Status_____ Occupation_____

Address_____ Postal Code_____

Home Telephone_____ Work Telephone_____

Email_____

When is the best time to call and where?_____

Why did you select our office?_____

Who may we thank for referring you?_____

Medical History:

Are you being treated for any medical conditions at the present or have you been treated within the last year?
Yes ☐ No ☐ Not Sure ☐

If so why?_____

When was your last medical checkup?_____

Has there been any change in your general health in the last year? Yes ☐ No ☐ Not Sure ☐
If yes, please explain:_____

Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? Yes ☐ No ☐ Not Sure ☐
If yes, please list:_____

_____

Do you have any allergies? If you answered yes, please list using the categories below: Yes ☐ No ☐ Not Sure ☐
Medications:_____
Latex/Rubber Products:_____
Other (e.g. Hayfever, foods):_____

Have you ever had a peculiar or adverse reaction to any medicines or injections? Yes ☐ No ☐ Not Sure ☐
If yes, please explain:_____

Do you have or have you ever had asthma? Yes ☐ No ☐ Not Sure ☐

Do you have or have you ever had any heart or blood pressure problems? Yes ☐ No ☐ Not Sure ☐

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis); a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice, or liver disease? Yes ☐ No ☐ Not Sure ☐

Do you have a prosthetic or artificial joint? Yes ☐ No ☐ Not Sure ☐

Do you have a bleeding problem or disorder? Yes ☐ No ☐ Not Sure ☐
If yes, please explain:_____

PLEASE CONTINUE ON REVERSE

CitiPlace Dental & Hygiene

Have you ever been hospitalized for any illness or operations? Yes ☐ No ☐ Not Sure ☐
If yes, please explain:_____

Do you have any conditions or therapies that could affect your immune system e.g. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
Yes ☐ No ☐ Not Sure ☐

Do you have any of the following? Please Check.

☐ Alzheimers	☐ Epilepsy or Seizures	☐ Lung Disease	☐ Shortness of Breath
☐ Angina	☐ Fibromyalgia	☐ Lupus	☐ Steroid Therapy
☐ Anemia	☐ Thyroid Disorder	☐ Migraines	☐ Stomach Ulcers
☐ Arthritis	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Stroke
☐ Blood Transfusion	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ TMJ Disorder
☐ Chest Pain	☐ High/ Low Blood Pressure	☐ Parkinsons Disease	☐ Tuberculosis
☐ Diabetes	☐ Hodgkins Disease	☐ Radiation/Chemotherapy	☐ Sexually Transmitted Infection
☐ Drug/ Alcohol Dependency	☐ Hypo/Hyperglycemia	☐ Rheumatic Fever	
☐ Emphysema	☐ Kidney Disease		

Are there any conditions or diseases not listed above that you have had or have? Yes ☐ No ☐ Not Sure ☐
If yes, please list:_____

Are there any diseases or medical problems that run in your family? (e.g. Diabetes, Cancer, Heart Disease)
Yes ☐ No ☐ Not Sure ☐
If yes, please explain:_____

Do you smoke or chew tobacco products? Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment? Yes ☐ No ☐ Not Sure ☐

Medical Contact:

Medical Doctor_____ **Telephone**_____

Emergency Contact Person:_____ **Telephone:**_____

Insurance Information:

Primary Insurance:

Name of Policy Holder _____
Policy Holder's Employer _____
Policy Holder's Date of Birth _____
Relationship to Patient _____
Insurance Company _____
Policy/Group Number _____
ID/Cert. Number _____

Secondary Insurance:

Name of Policy Holder _____
Policy Holder's Employer _____
Policy Holder's Date of Birth _____
Relationship to Patient _____
Insurance Company _____
Policy/Group Number _____
ID/Cert. Number _____