AMWELL DENTAL ASSOCIATES

PATIENT'S MEDICAL HEALTH INFORMATION

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 density you will receive. Thank you for answering the following questions.

General Health	Physician's Name		
Excellent ☐ Good ☐ Fair ☐ Poor ☐			
Physician's Street Address	City	State	Zip Code
Date of Last Complete Physical / /	Results	Are you Taking Medication Now?	Purpose of Medication

ARE YOU OR HAVE YOU BEEN TREATED FOR:

Heart Disease	Yes ☐ No ☐	Anemia	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐
Rheumatic Fever	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Cough	Yes ☐ No ☐
☐High/☐Low Blood Pressure	Yes ☐ No ☐	A.I.D.S./HIV	Yes ☐ No ☐	Hepatitis/Jaundice	Yes ☐ No ☐
Ulcer/Stomach	Yes ☐ No ☐	Cancer	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
TB or Lung Disease	Yes ☐ No ☐	Congenital Heart Lesions	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Venereal Disease/STD	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Asthma or Hay Fever	Yes ☐ No ☐	Joint or Limb Replacement	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐			Liver/Kidney Disease	Yes ☐ No ☐

Have you ever been treated (other than diagnostic) with X-ray?	Have you ever had a blood transfusion?	Cancer/Radiation Treatment:
Yes ☐ No ☐ If yes, explain:	Yes ☐ No ☐ If yes, date:	
Are you Allergic to		Any other known Allergies:
Penicillin: Yes ☐ No ☐ Codeine: Yes ☐ No ☐ Local Anesthetics: Yes ☐ No ☐ Latex: Yes ☐ No ☐		
Are you subject to prolonged bleeding? Yes ☐ No ☐	Are you subject to Fainting Spells? Yes ☐ No ☐	Do you have excessive urination and/or thirst? Yes ☐ No ☐

WOMEN ▸	Are you Pregnant? Yes ☐ No ☐	If Yes, How Long?	Any Complications?

ARE YOU CURRENTLY TAKING MEDICATIONS? — **IF YES, PLEASE LIST MEDICATION AND PURPOSE**

MEDICATION	PURPOSE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Do you have any other Medical Conditions you feel we should know? Are you currently under any medical treatment now?

To the best of my knowledge, the questions on this form have been accurately answered. 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.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE _____

AMWELL DENTAL ASSOCIATES

Please fill out form COMPLETELY. Thank you.

Date / /

PATIENT INFORMATION

Patient's Name | Home Phone ( ) | Work Phone ( ) | Cell Phone ( )

Street Address | City | State | Zip Code

Patient's Date of Birth / / | Sex Male ☐ Female ☐ | Height | Weight | Social Security No.

Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ | Occupation | Student Status: ☐ Full Time ☐ Part Time Name of School

Purpose of Visit | How Were you Referred to this Office? | Email Address

PATIENT'S EMPLOYER'S INFORMATION

Employer's Name

Street Address | City | State | Zip Code

SPOUSE'S INFORMATION

Spouse's Name | Home Phone ( ) | Work Phone ( )

IN CASE OF EMERGENCY - NEAREST RELATIVE NOT LIVING WITH YOU

Relative's Name | Relationship | Home Phone ( ) | Work Phone ( )

Street Address | City | State | Zip Code

PERSON RESPONSIBLE FOR ACCOUNT INFORMATION: (IF SOMEONE OTHER THAN PATIENT)

Drivers License _____

Name _____ Employer Name _____

Address _____ Employer Address _____

Town _____ State _____ Zip _____ Town _____ State _____ Zip _____

Home # _____ SS # _____ Work # _____

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insurance: _____

Address _____ Town _____ State _____ Zip _____

Name of Insured _____ DOB of Insured _____ Soc. Sec. # of Insured _____

Insured's Employer _____ Policy or ID # _____

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insurance: _____

Address _____ Town _____ State _____ Zip _____

Name of Insured _____ DOB of Insured _____ Soc. Sec. # of Insured _____

Insured's Employer _____ Policy or ID # _____

SIGNATURE ON FILE AUTHORIZATION

☐ I authorize use of this form on all my insurance submissions

☐ I authorize release of information to all my insurance carriers

☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers

☐ I permit a copy of this authorization to be used in place of the original

Signature of Insured _____ Date _____