Time 1:57 PM | Middlebury Dental Group | Date 2/14/2019

Medical History 2019 NEW

Patient Name: | Birth Date: | Date Created:

Please check any of the following that apply to you

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth Pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or Fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, Chipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you smoke or use chewing tobacco? ◯ Yes ◯ No

Allergies

Do you have any of the following drug allergies?

Aspirin	◯ Yes ◯ No	Codeine	◯ Yes ◯ No	Erythromycin	◯ Yes ◯ No	Nirtous Oxcide	◯ Yes ◯ No
Valium	◯ Yes ◯ No	Percocet	◯ Yes ◯ No	Local Anesthetic	◯ Yes ◯ No	Sulfa Drugs	◯ Yes ◯ No
Oxycodone	◯ Yes ◯ No	Percodan	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No	Amoxicillin	◯ Yes ◯ No

Other: ◯ Yes ◯ No If yes

Health care

Do you have a primary Dr. Please list ◯ Yes ◯ No If yes

Are you seeing a specialist? ◯ Yes ◯ No If yes

Please check any of the following that apply to you:

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart condition
- ☐ Heart Lesions
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Depression
- ☐ Pacemaker
- ☐ Phen Fen
- ☐ Pregnant
- ☐ Radiation
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Veneral Disease

Medications

Are you taking any medications? Please list ◯ Yes ◯ No If yes

Is there any other medical or dental information we should know about? ◯ Yes ◯ No If yes

Signature of Patient, Parent or Guardian:

X Date:_____

Welcome To Middlebury Dental Group

We are pleased to welcome you to our office. Please take a few minutes to fill out this form.
If you have any questions, we'll be glad to help.

PATIENT INFORMATION

Patient Name _____
First Last MI (Preferred)

Address _____ Address 2 _____

City _____ State _____ Zip _____

Hm Phone _____ Cell_____ Work_____

Preferred contact method for confirmations: [ ] HmPhone [ ] WkPhone [ ] Mobile Phone [ ] Text [ ] E-mail

E-mail address _____

Date of Birth:_____ Sex: [ ] Female [ ] Male Social Sec #_____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

New Patient? [ ] Y [ ] N *If yes, how did you hear of our office?* _____

RESPONSIBLE PARTY- *required if patient is a child, or if policy holder of insurance is someone other than patient.*

Name of Responsible _____
First Last MI (Preferred)

Check box if address is same for entire family [ ] If address if different, please enter below

Address _____ Address 2 _____

City _____ State _____ Zip _____

Hm Phone _____ Cell_____ Work_____

Preferred contact method for confirmations: [ ] HmPhone [ ] WkPhone [ ] Mobile Phone [ ] Text [ ] E-mail

E-mail address _____

Date of Birth:_____ Sex: [ ] Female [ ] Male Social Sec #_____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

INSURANCE POLICY 1 (*Primary*)

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Name _____ Subscriber DOB _____

Employer _____ Subscriber ID # _____

Insrance Company _____ Group # _____

Ins. Co Address _____ Subscriber Social Sec #_____

INSURANCE POLICY 2 (*Secondary*)

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber Name _____ Subscriber DOB _____

Employer _____ Subscriber ID# _____

Insrance Company _____ Group # _____

Ins. Co Address ____ Subscriber Social Sec # ____________________