Legends DENTAL
GEORGE JEDLICKA, DMD

Adult Information and Health History

PATIENT INFORMATION **TODAY'S DATE _____**

LAST NAME _____ FIRST NAME _____ INITIAL _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ DRIVER'S LICENSE NUMBER _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHYSICAL ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE NUMBER _____ WORK PHONE NUMBER _____ EXTENSION _____

CELL PHONE NUMBER _____ EMAIL ADDRESS _____

EMPLOYER NAME & ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PREFERRED METHOD OF CONTACT _____ EMERGENCY CONTACT (NON SPOUSE) _____

SPOUSE INFORMATION _____ CONTACT NUMBER _____ DATE OF BIRTH _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____ INSURED PERSON _____ DATE OF BIRTH _____

ID NUMBER OR SSN _____ GROUP NUMBER _____ EMPLOYER _____

INSURANCE MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE CARRIER _____ INSURED PERSON _____ DATE OF BIRTH _____

ID NUMBER OR SSN _____ GROUP NUMBER _____ EMPLOYER _____

INSURANCE MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

Patient Name_____
Last First Initial

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER PLEASE WRITE <u>DON'T KNOW</u> ON THE LINE AFTER THE QUESTION.

1. Physician's Name_____
   Address_____
2. Are you under a Physician's care?…… YES NO
3. When was your last complete physical exam?……..._____
4. Are taking any medication or substances?…… YES NO
   (If yes, please list medications in the "comments" box to the right)
5. Do you routinely take health related substances?…….. YES NO
6. Are you allergic to any medications or substances?…….. YES NO
7. Do you have any other allergies……YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?……... YES NO
9. Are you sensitive to any metals or latex?……... YES NO
10. Are you pregnant or suspect you may be?…….. YES NO
11. Do you use any birth control medications?…… YES NO
12. Have you ever been treated for or been told you might have heart disease?YES NO
13. Do you have a pacemaker or artificial heart valve implant?…….. YES NO
14. Have you ever had rheumatic fever?…….. YES NO
15. Are you aware of any heart murmurs?…… YES NO
16. Do you have high or low blood pressure?…… YES NO
17. Have you ever had a serious illness or major surgery?…… YES NO
    If so, explain_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?……..... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism?.....YES NO
20. Do you have any artificial joints / prosthesis?…… YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc?…… YES NO
22. Have you ever bled excessively after being cut or injured?……... YES NO
23. Do you have any stomach problems?…… YES NO
24. Do you have any kidney problems?…….. YES NO
25. Do you have any liver problems?…….. YES NO
26. Are you diabetic?…… YES NO
27. Do you have asthma?……YES NO
28. Do you have epilepsy or seizure disorders?……... YES NO
29. Do you or have you had a venereal disease?……. YES NO
30. Have you tested HIV positive?…… YES NO
31. Do you have AIDS?…… YES NO
32. Have you had or do you test positive for hepatitis?…..A B or C…….. YES NO
33. Do you or have you had T.B?…… YES NO
34. Do you smoke, chew, use snuff or any other form of tobacco?…… YES NO
35. Do you consume alcoholic beverages?…….. YES NO
36. Do you habitually use controlled substances?…… YES NO
37. Have you had psychiatric treatment?……. YES NO
38. Do you have any disease, condition, or problem not listed?…….. YES NO
    If so, explain _____
39. Is there anything else we should know about your health that we have not covered in this form?_____

Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN SIGNATURE_____DATE_____