

WELCOME TO OUR OFFICE!!

Dr. Lee Zuidema and Staff

Please fill this form out completely so that we as a dental team can meet your dental needs using the most recent medical and dental information available.

Today's Date: _____

Home Phone #: _____ Cell #: _____

Name: _____ Birth Date: ___/___/___ Age: _____ SS# _____

Address: _____

_____ city _____ state _____ zip code

Parent / Guardian Names: _____

Does patient have dental insurance? _____ yes _____ no

Insured's Name _____ Insured Date of Birth ___/___/___

Insured's Social Security # _____

Insured's Employer _____

Dental Insurance Co.: _____ Ins. Co. Phone #: _____

Dental Insurance Company Address: _____

Group # (plan, local, or policy #): _____

Is patient covered by a secondary dental plan? yes _____ no _____ Secondary Ins. Co. : _____

Insured's Name: _____ SS # _____ BD ___/___/___

Insured's Employer: _____ Group or policy # : _____

Are there any changes regarding patient's dental health? _____

In case of an emergency, whom should we contact?:

Their name: _____ Phone # _____ Relationship to you _____



**MEDICAL
HISTORY
UPDATE**

Is patient currently under the care of a physician? Yes _____ No _____

Please explain: _____

Physician's Name: _____ Phone # _____

Your current physical health is : good _____ fair _____ poor _____

Please list any medications patient is currently taking and why patient is taking them :

Is patient allergic to any of the following? (Please check if yes)

Acrylic	_____	Sulfa	_____
Penicillin	_____	Aspirin	_____
Tetracycline	_____	Latex	_____
Erythromycin	_____	Metals	_____
Codeine	_____	Other	_____
Dental Anesthetics (Epinephrine, Novocain, etc.)	_____		_____

Has patient had any of the following diseases or medical problems? (Please check if yes)

Heart attack/stroke	_____	Radiation	_____
Heart murmur	_____	Cancer/Chemo	_____
Heart surgery	_____	Shingles	_____
Congenital heart def.	_____	Kidney disease	_____
Mitral Valve Prolapse	_____	Pacemaker	_____
		Artificial joints/bones	_____
Rheumatic fever	_____	Diabetes	_____
High blood pressure	_____	Hepatitis	_____
Low blood pressure	_____	Psychiatric care	_____
Artificial valves	_____	Epilepsy/seizures	_____
		Cold sores/herpes	_____
Hemophilia/blood dis.	_____	Drug/alcohol addict.	_____
Blood transfusions	_____	Venereal disease	_____
HIV+/AIDS	_____	Ulcers/colitis	_____
Anemia	_____	Arthritis	_____
		Frequent headaches	_____
Tuberculosis	_____	Sinus conditions	_____
Asthma	_____	Glaucoma	_____
Difficulty breathing	_____		
Emphysema	_____		

Has patient been hospitalized recently? Yes _____ No _____ Reason: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. **In the event that a health care worker comes in contact with the patient's blood or other potentially infectious body fluids while treating them, I hereby consent to a hepatitis and HIV antibody test. These tests will be at no charge to the patient.**

X _____ Date ____/____/____
signature

Updated Health History (sign)	_____	Date	_____
Updated Health History (sign)	_____	Date	_____
Updated Health History (sign)	_____	Date	_____
Updated Health History (sign)	_____	Date	_____