Croasdaile DENTAL ARTS
Your Smile. Our Passion.

ADULT MEDICAL HISTORY FORM pg1

SELECT YOUR DENTIST: **DATE: _____**

___ Dr. Will Turner **____ Dr. Jason Butler** **____ Dr. Virginia Mayo**

PATIENT INFORMATION: ___Married ___Single
Name _____ ___Male___Female
(LAST) (FIRST) (MIDDLE INITIAL)
What name would you like to be called in this office? _____
Whom may we thank for referring you?_____

FAMILY INFORMATION:

SELF
Name: _____
Address:_____
City _____ State _____ Zip _____
Home# _____Work_____Ext___
Cell # _____ Pager _____
Email: _____
Birthdate: _____ SSN#:_____
Employer/Occupation: _____

SPOUSE
Name: _____
Address:_____
City_____ State _____ Zip _____
Home# _____Work_____Ext___
Cell # _____ Pager _____
Email: _____
Birthdate: _____ SSN#:_____
Employer/Occupation: _____

Please name two people to contact outside of immediate family in case of emergency: (not living with you)
Name: _____ Home# _____ Work#_____
Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Home# _____ Work#_____
Address: _____ City: _____ State: _____ Zip: _____

FINANCIAL INFORMATION: (note: please review our Financial Policy form)
Please check the person financially responsible for the account
____ Patient ____ Father ___ Mother ____Guardian ____Spouse ___Other (specify) _____

Does responsible party have an account with this office ____Yes ____ No
Method of Payment: ____ Check _____ Cash ____ Mastercard/Visa
Where appropriate and necessary, credit bureau reports will be obtained.

Dental Insurance 1
Employee Name: _____
Employer Name: _____
Insurance Co. Name: _____
Insurance Co. Address:_____
_____
Subscriber I.D. #: _____
Group #: _____
Employee Date of Birth: _____

Dental Insurance 2
Employee Name: _____
Employer Name: _____
Insurance Co. Name: _____
Insurance Co. Address:_____
_____
Subscriber I.D. #: _____
Group #: _____
Employee Date of Birth: _____

Authorization:
I hereby authorize payment directly to the Drs. Turner & Butler, DMD, PA, as well as, the Associate dentist of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Patient Signature: _____ Date: _____ State Driver's License #:_____

Please complete the following page regarding Medical History

Patient Name: _____ **Birth Date:** _____ **Pg 2**

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

Are you under a physician's care now? ___ Yes ___ No If yes, please explain _____
Please list the name of your primary care physician and number: _____
Have you ever been hospitalized or had a major operation? ___ Yes ___ No If yes, please explain _____
Have you ever had a serious head or neck injury? ___ Yes ___ No If yes, please explain _____
Are you taking any medications? (Rx, OTC, Supplements) ___ Yes ___ No If yes, please list all here _____
_____
_____
_____

Do you take, or have you taken, Phen-Fen or Redux? ____Yes ___ No If yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ____Yes ___ No If yes, please explain _____
Are you on a special diet? ____Yes ___ No If yes, please explain _____
Do you use tobacco? ____Yes ___ No Do you use controlled substances? ____Yes ___ No
Do you have sleep apnea? ____Yes ___No Do you use a C-PAP machine? ____Yes ___No
Do you use Electronic cigarette? ____Yes ___No Do you have hearing loss? ____Yes ___No

Women:
____ Pregnant or Trying to get pregnant?
____Nursing?
____Taking oral contraceptives or other hormones

Men:
____Do you take medications for erectile dysfunction?
____Do you have a history of prostate cancer?

Are you allergic to any of the following?
____ Aspirin ____Penicillin ____Codeine ____ Acrylic ____Metal____ Latex ____Sulfa Drugs ____ Local Anesthetics
____ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

____ AIDS/HIV Positive	____ Chest Pains	___Genital Herpes	___ Kidney Problems	___ Rheumatism
____ Alzheimer's Disease	____ Cold Sores/Fever Blisters	___Glaucoma	___ Leukemia	___ Scarlet Fever
____ Anaphylaxis	____ Congenital Heart Disorder	___Hay Fever	___ Liver Disease	___ Shingles
____ Anemia	____ Convulsions	___Heart Attack/Failure	___ Low Blood Pressure	___ Sickle Cell Disease
____ Angina	____ Cortisone Medication	___Heart Murmur	___ Lung Disease	___ Sinus Trouble
____ Arthritis/Gout	____ Diabetes	___Heart Pace Maker	___ Mitral Valve Prolapse	___ Spina Bifida
____Artificial Heart Valve	_____ Drug/Alcohol Addiction	___Heart Trouble/Disease	___ Organ Transplant	___ Stomach/Intestinal
____ Artificial Joint	_____ Easily Winded	___ Hemophilia	___ Osteoporosis	___ Stroke
____ Asthmas	_____ Emphysema	___ Hepatitis A	___ Pain in Joints	___ Swelling of Limbs
____ Blood Clot/DVT	_____ Epilepsy or Seizures	___ Hepatitis B or C	___ Parathyroid Disease	___ Thyroid Disease
____ Blood Disease	_____ Excessive Bleeding	___ Herpes	___ Psychiatric Care	___ Tonsillitis
____ Blood Transfusion	_____ Excessive Thirst	___ High Blood Pressure	___ Radiation Treatment	___ Tuberculosis
____ Breathing Problems	_____ Fainting Spells/Dizziness	___ High Cholesterol	___ Recent Weight Loss	___ Tumors or Growths
____ Bruise Easily	_____ Frequent Cough	___ Hives or Rash	___ Renal Dialysis	___ Ulcers
____ Cancer	_____ Frequent Diarrhea	___ Hypoglycemia	___ Rheumatic Fever	___ Venereal Disease
____ Chemotherapy	_____ Frequent Headaches	___ Irregular Heartbeat		

Have you ever had any serious illness not listed above? ____ Yes ____ No If yes, please explain: _____
_____

Comments: _____
_____

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.

I understand that Croasdaile Dental Arts (Drs. Turner & Butler, DMD, PA) and their associate dentist requires that a new Medical History Form be completed once a year.
Signature of Patient, Parent or Guardian _____ **Date:** _____