Wethersfield DENTAL GROUP

Patient Information/Medical History

Please Print

Patient Name _____ **Date of Birth** ___/___/___ **Age** ____ **Marital Status**: S__ M__ D__ W__

Mailing Address _____ **Town**_____ **Zip Code**_____

HOME phone number_____ **CELL/MOBILE phone number** _____

Email Address _____ **Appt confirmation preference**: phone call____ text____email____

Parent Name (first and last) if patient is a child _____

Who may we thank for referring you to Wethersfield Dental Group?_____

Dental Insurance Information (please present insurance card to front desk staff)

Subscriber Name:_____ **Subscriber Date of Birth:** _____

Subscriber Social Security Number_____-_____-_____

Insurance Carrier Name_____ **Insurance phone number**_____

Insurance Address _____

Insurance ID#_____ **Payer ID#**_____ **Group #**_____

Name of person responsible for payment_____**Employer phone number** _____

Medical History: PHYSICIAN'S NAME_____ DATE OF LAST PHYSICAL EXAM_____

PREVIOUS DENTIST NAME_____ DATE OF LAST THOROUGH DENTAL EXAM_____

ANSWER ALL QUESTIONS (Check YES or NO)

Y___ N___	Angina Pectoris	Y___ N___	Circulatory Problems	Y___ N___	Hepatitis
Y___ N___	Heart Murmur	Y___ N___	Stroke	Y___ N___	Rheumatic Fever
Y___ N___	Heart Problems	Y___ N___	Sinus Problem	Y___ N___	AIDS
Y___ N___	High Blood Pressure	Y___ N___	Asthma	Y___ N___	STDs
Y___ N___	High Cholesterol	Y___ N___	Diabetes	Y___ N___	Kidney Disease
Y___ N___	Microvalve Prolapse	Y___ N___	Jaundice	Y___ N___	Arthritis
Y___ N___	Nervous Problems	Y___ N___	Scarlet Fever	Y___ N___	Artificial Valves
Y___ N___	Psychiatric Treatment	Y___ N___	Tonsillitis	Y___ N___	Artificial Bones/Joints
Y___ N___	Malignancies	Y___ N___	Tuberculosis	Y___ N___	Cancer
Y___ N___	Epilepsy	Y___ N___	Ulcer		
Y___ N___	Mononucleosis	Y___ N___	Excessive Bleeding		

Are You Allergic to any of the following?

Y___ N___	Penicillin	Y___ N___	Codeine	List any other allergies:
Y___ N___	Aspirin	Y___ N___	Latex	_____
Y___ N___	Erythromycin	Y___ N___	Anesthetics	_____
Y___ N___	Tetracycline			_____

Are you pregnant?_____ Have you been hospitalized or had surgery in the last 12 months? _____

Have you ever been told that you should be pre-medicated for medical or dental appointments?_____

Are you taking any medication?_____ If yes, what and dosage?_____

--Office Use Only—

I have reviewed the Medical/Dental information above with the patient herein.

_____ _____

(**Doctor Signature**) (Date)

Doctor's Notes: