Medical history Date_____

Sonoran Sky Dental

Patient Information Full Name *(print)* _____Date of Birth_____/_____/_____

Address_____City_____ State_____ ZIP_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Marital Status_____

S.S#_____-_____-_____ Sex _____ Height _____ Weight _____

Occupation/Employer_____Position_____ Work Phone _____

Part time____ Full time_____ ***Full time college students using their parents coverage may need to provide proof of full time student status***

Email _____

Emergency Contact Name_____ Relationship to patient _____

Home phone_____ Cell phone_____

**How did you hear about us? [ ] Friend/Relative_____[ ] Insurance_____[ ] Other_____

Responsible party (Guarantor): Relationship to Patient: _____

Name_____ DOB_____ Sex_____

Address_____City_____State_____ZIP_____

Home Phone (_____) _____-_____ Work/Cell Phone (_____) _____-_____ S.S#_____

Email_____

Occupation/Employer_____Position_____ Work Phone _____

Primary Dental Insurance

Subscriber's name _____ DOB _____ Relationship to Patient: _____

Employer_____ Insurance Company_____

Policy ID# or S.S# _____

Secondary Dental Insurance

Subscriber's name _____ DOB _____ Relationship to Patient: _____

Employer_____ Insurance Company_____

Policy ID# or S.S# _____

Primary Physician's Name _____ Number (_____) _____-_____

Date of last physical exam _____ Are you now under a physician's care for a particular problem? YES [ ] NO [ ]

If yes, please explain. _____

Reference:

1) Name: _____Phone number: _____Relationship_____

Pharmacy Name and Phone number: _____ ( ) _____

I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of services. I understand that I am financially responsible for all charges of services performed by the provider. If the insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of services to release all information necessary to secure the payment for services rendered. Failure to provide complete information may result in receiving a bill for services rendered. I am aware that by signing below I certify that all the information is complete and correct to the best of my knowledge.

Print name: _____ Patient Signature: _____ Date: _____

Parent/Guardian:

Medical history Date_____

Print name: _____ Signature: _____ Relationship _____ Date: _____

Please check the following that apply to you: Please check YES or NO

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	AIDS	☐	☐	Ear ache	☐	☐	Hives/ rash	☐	☐	Seizures
☐	☐	Alzheimer's disease	☐	☐	Emphysema	☐	☐	Implants_____	☐	☐	Shortness of breath
☐	☐	Anemia	☐	☐	Excessive bleeding			_____	☐	☐	Sickle cell disease
☐	☐	Angina/ chest pain	☐	☐	Fainting/ dizziness	☐	☐	Kidney problems	☐	☐	Skin sores/ blisters
☐	☐	Arthritis	☐	☐	Genital herpes	☐	☐	Leukemia	☐	☐	Stomach ulcers or colitis
☐	☐	Artificial joints	☐	☐	Glaucoma	☐	☐	Liver disease	☐	☐	Stroke (year_____)
☐	☐	Asthma	☐	☐	Gout	☐	☐	Nervous disorder	☐	☐	Swelling of limbs
☐	☐	Bleeding problem	☐	☐	Head injury	☐	☐	Nervous of dentist	☐	☐	Thyroid problem
☐	☐	Blind	☐	☐	Headaches	☐	☐	On dialysis	☐	☐	Trying to get pregnant
☐	☐	Bone plates/ screws	☐	☐	Hearing problem	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Breathing problems	☐	☐	Heart attack/ failure	☐	☐	Pain in the jaw joint	☐	☐	Tumor or growths
☐	☐	Bronchitis	☐	☐	Heart disease	☐	☐	Parathyroid disease	☐	☐	Venereal disease
☐	☐	Bruise easily	☐	☐	Heart murmur	☐	☐	Pneumonia	☐	☐	Wheelchair patient
☐	☐	Bruxism	☐	☐	Heart surgery	☐	☐	Portal hypertension	☐	☐	Other_____
☐	☐	Cancer_____	☐	☐	Heart valve problems	☐	☐	Prosthetic hip or joint	☐	☐	_____
☐	☐	Cerebral palsy	☐	☐	Hepatic infection	☐	☐	Psychiatric care			**For Woman Only:**
☐	☐	Congenital heart disease	☐	☐	Hepatitis B	☐	☐	Recent blood transfusion	☐	☐	Pregnant months_____
☐	☐	Convulsion/ epilepsy	☐	☐	Hepatitis C	☐	☐	Respiratory disease	☐	☐	Nursing
☐	☐	Cortisone medicine	☐	☐	High blood pressure	☐	☐	Rheumatic fever	☐	☐	Is there a chance you may be pregnant?
☐	☐	Crohn's disease	☐	☐	History of drug abuse	☐	☐	Rheumatic heart disease			
☐	☐	Deaf	☐	☐	HIV positive	☐	☐	Rheumatism			
☐	☐	Diabetes									
☐	☐	Digestive tract ulcer									

Reason for today's visit: _____

List and/or Explain Other Medical Conditions not listed above: _____

Do you have any Allergies? Please check YES or NO.

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Acrylic	☐	☐	Latex	☐	☐	Sulfa	☐	☐	Metal; type_____
☐	☐	Acetaminophen	☐	☐	Aspirin	☐	☐	Lidocaine	☐	☐	Ibuprofen
☐	☐	Amoxicillin	☐	☐	Penicillin	☐	☐	Codeine	☐	☐	Other _____
☐	☐	Iodine	☐	☐	Vicodin	☐	☐	Epinephrine			

Are you taking any of the following? Please check YES or NO

YES	NO		YES	NO		YES	NO	
☐	☐	Aspirin/Blood thinners	☐	☐	Bisphosphonate Reason: _____	☐	☐	Blood pressure medicine
☐	☐	Cortisone (Steroids)	☐	☐	Insulin, tolbutamide (orinase) or similar drug	☐	☐	Oral contraceptive
☐	☐	Drugs for heart trouble	☐	☐	Radiation therapy –reason _____			

Do you take any other medications? Yes [ ] NO [ ] (if yes please list all Medications) _____ _____

_____ _____ _____ _____

Have you had a serious illness/operation or hospitalization? YES [ ] NO [ ] If YES what year? _____

Explain reason and condition _____

Due to pre-existing medical conditions, is pre-medication required for dental treatment? YES [ ] NO [ ] If *yes, please specify medication and its instructions* _____

By signing below, I acknowledge that I have read and understand the above medical questionnaire. That the information on this form provided is essential to determine my medical/cosmetic needs and provision of the treatment plan and that I will have the opportunity to discuss my health history with my doctor during this appointment. If any changes occur in my health/history I will report it to the office as soon as possible in writing. I acknowledge that all answers have been truthful and I will not hold any of the staff responsible for any error or omissions that I have made in the completion. I consent to the examination and/or treatment of myself and all minor children listed, to Sonoran Sky Dental personnel.

Print Name _____ Date: _____

Patient Signature _____ Relationship _____

Doctor Signature _____ *Date:* _____

Medical Update: I have read my Health History dated_____ and confirm that it adequately states past and present Conditions. Exception or changes _____

Patient's signature _____Date _____ Doctor's initials_____