ANTHONY E. BISCONTI D.D.S., INC.

MEDICAL HISTORY

DATE: _____

(For your health's sake, you must be accurate.)

Name of person completing this form: _____

Patient: _____

Age: _____ Height: _____ Weight: _____

(circle)

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years: ..... YES NO
6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you allergic to (ie., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ..... YES NO
8. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO
9. Circle any of the following which you have had or have at present.

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Chronic Bronchitis	Hepatitis A (Infectious)
Angina Pectoris	Cough	Hepatitis B (serum)
High Blood Pressure	Tuberculosis (TB)	Liver Disease
Heart Murmur	Asthma	Yellow Jaundice
Rheumatic Fever	Hay Fever	Blood Transfusion
Congenital Heart Lesions	Sinus Trouble	Drug or Alcohol Abuse
Scarlet Fever	Allergies or Hives	Hemophilia
Artificial Heart Valve	Diabetes	Venereal Disease (Syphillis, Gonorrhea)
Mitral Valve Prolapse	Thyroid Disease	Cold Sores
Heart Pacemaker	X-Ray or Cobalt Treatment	Genital Herpes
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Epilepsy or Seizures
Artificial Joint	Arthritis	Fainting or Dizzy Spells
Anemia	Rheumatism	Nervousness
Stroke	Cortisone Medicine	Psychiatric Treatment
Kidney Trouble	Glaucoma	Sickle Cell Disease
Ulcers	Pain in Jaw Joints	Bruise Easily

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Do you have any disease, condition or problem not listed? ..... YES NO
18. WOMEN: Are you pregnant now? ..... YES NO
    Are you practicing birth control? ..... YES NO
    Do you anticipate becoming pregnant? ..... YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Signature: _____

If you answered YES to any of the above questions, please explain below. (You can use the back of this page if necessary.)

_____

_____

Continued on back side

A B C

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Birthdate _____ Home Phone _____ Cell Phone _____ Work Phone _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ❑ No ❑ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's Signature if minor) _____

Updates (date & initial)_____ _____ _____ _____ _____

CONFIDENTIAL (for record and treatment evaluation)