PATIENT MEDICAL HISTORY FORM

GEORGE R. COOPER, D.D.S.

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Fort Wayne, Indiana 46825
(260) 489-1508

Date _____

PERSONAL INFORMATION

Name (Mr., Mrs., Ms., Rev., Dr.) _____

What do you prefer to be called_____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Email Address_____

Marital Status _____ Social Security # _____

Birthdate _____ If a child, parents names_____

Spouse _____Other family members _____

Whom may we thank for referring you _____

Emergency Contact _____ Phone _____

EMPLOYMENT INFORMATION (or parent's employer)

Your occupation _____ Employed by_____

Address _____ Phone # _____

Spouse employed by _____

Address _____ Phone # _____

ACCOUNT INFORMATION

Do you have dental insurance Y N

Primary Insurance Company _____ Group #_____

Insured's Name _____ Soc. Sec. No. _____ Date of birth_____

Send Claims to _____ Alternate ID # _____

Relationship to Patient _____

Secondary Insurance Company _____ Group #_____

Insured's name _____ Soc. Sec. No. _____ Date of Birth_____

Send Claims to _____ Alternate ID # _____

Relationship to Patient _____

Who is responsible for your dental expenses Name_____

Address _____ Phone # _____

HEALTH INFORMATION

Do you have or have you had any of the following: (Please check yes or no)

	Y	N		Y	N		
Tuberculosis (TB)	❑	❑	Hepatitis-Type _____	❑	❑	Respiratory Disease	
Require Premedication	❑	❑	HIV+/AIDS	❑	❑	Asthma	
Rheumatic Fever	❑	❑	Artificial Joint	❑	❑	Stroke	
Pace Maker	❑	❑	Thyroid Problems	❑	❑	Neurological Disorder	
High Blood Pressure	❑	❑	Anemia	❑	❑	Ulcers/Colitis	
Heart Valve Condition (MitralValve Prolapse, Murmur)	❑	❑	Abnormal Bleeding after extraction or injury	❑	❑	Steroid Therapy	
						Persistent/Bloody Cough	
Other Heart Problem	❑	❑	Cancer	❑	❑	Pregnant Now	
Diabetes	❑	❑	Chemotherapy	❑	❑	Nursing	
Kidney Disease	❑	❑	Radiation Therapy	❑	❑		
Liver Disease	❑	❑	Seizures	❑	❑		

Have there been any significant changes in your health in the last five years _____

Are you currently under the care of a physician Y N Family Physician _____

Further information explaining any YES answers _____

_____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS

_____

_____

_____

_____

ALLERGIES

❑ Latex ❑ Other _____

❑ Codeine _____

❑ Penicillin _____

❑ Sulfa _____

❑ Local Anesthetic ❑ None

Date of last dental visit _____ Dental xrays _____ Name of previous dentist _____

Purpose of today's visit _____

OFFICE USE ONLY

DATE / REVISIONS	DATE / REVISIONS