



Patient Information and Medical History

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Gender: _____ Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Referred by: _____ Emergency Contact Name & Phone: _____

Parent or guardian (if under 18): _____ Phone: _____

Address: _____ SSN: _____

Employer: _____ Date of Birth: _____

Spouse: _____ Phone: _____

Address: _____ SSN: _____

Employer: _____ Date of Birth: _____

Please answer each of the following:

1. Date of last physical examination _____ Physicians name: _____

2. Have you been under the care of the physician in the past two years? No Yes, _____

3. Have you been hospitalized during the last two years? No Yes, _____

4. Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? No Yes, _____

5. Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by any foods or any other non medicinal items? No Yes, _____

6. Have you been out of the country in the past six (6) months? No Yes, _____

7. Have you had any contact with anyone who has been out of the country in the last six (6) months? No Yes, _____

Women:

8. Are you pregnant? No Yes Are you nursing? No Yes Are you taking birth control pills? No Yes
Weeks _____

9. Check any of the following you have **had** or **have at present**:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> *Mitral Valve Prolapse | <input type="checkbox"/> *Any type of Transplant | <input type="checkbox"/> *Rheumatic Fever | <input type="checkbox"/> *Autism |
| <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> *Heart Murmur | <input type="checkbox"/> Angina | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Asthma | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV Positive, ARC, AIDS | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cortisone Medications | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> *Any type of Implant | <input type="checkbox"/> Use of Tobacco Products | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> *Congenital Heart Defect | <input type="checkbox"/> Heart Attack Date _____ | <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> *Artificial knee, hip or other joint |
| <input type="checkbox"/> Alzhiemers/Dementia | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Oral or IV Bisphosphonates |

* Antibiotic premedication may be required prior to your appointment

10. Are there any other health concerns we should be aware of?

11. Please list all medications that you are currently taking (including over the counter medications, vitamins, or herbal remedies):

Dental Insurance Information:

Name of Insurance Company : _____ Phone: _____

Subscriber's Name: _____ SSN: _____ Date of Birth: _____

Secondary Insurance Company: _____ Phone: _____

Subscriber's Name: _____ SSN: _____ Date of Birth: _____

Financial Responsibility: Self Other - Please complete information below

Name of Responsible Party : _____ Phone: _____

Relationship to Patient: _____ SSN: _____ Date of Birth: _____

BELTRAMI, DIXON, WOODARD, DDS PLC (DBA COMMONWEALTH DENTISTRY) FINANCIAL POLICY REQUIRES PAYMENT AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. Should my treatment be extensive, I may request additional information regarding financial plans. In the event that any balance on my account must be placed for collection, I agree to pay the collection agency fees up to 32%, reasonable attorney's fees, and all court costs. I understand that all amounts over 30 days after treatment are subject to finance charge of 1.5% per month (18% annual rate) I am aware that should I fail to keep an appointment without giving 24 hour notice, I will be charged a broken appointment fee.

Patient (or Guardians) Signature

Today's Date