Medical history Date_____

Sonoran Sky Dental

Patient Information Full Name *(print)* _____

Address_____City_____ State_____ ZIP_____

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

S.S#_____ DOB_____ Sex _____ Height _____ Weight _____

Occupation/Employer_____Position_____ Work Phone _____

Part time____ Full time____ ***Full time college students using their parents coverage must 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 _____ Employer_____

Insurance Company_____ DOB _____ Subscriber ID# or S.S# _____

Address_____City_____ State_____ ZIP_____

Secondary Dental Insurance Subscriber's name _____ Employer _____

Insurance Company_____ DOB _____ Subscriber ID# or S.S# _____

Address_____City_____ State_____ ZIP_____

References:

1) Name: _____Phone number: _____Relationship_____

2) Name: _____Phone number: _____Relationship_____

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 services. 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:

Print name: _____ Signature: _____ Relationship to patient: _____ Date: _____

Medical history Date_____

Please check the following you have or have had:

- ☐ AIDS
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Angina/ chest pain
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Bleeding problem
- ☐ Blind
- ☐ Bone plates/ screws
- ☐ Breathing problems
- ☐ Bronchitis
- ☐ Bruise easily
- ☐ Bruxism
- ☐ Cancer_____
- ☐ Cerebral palsy
- ☐ Congenital heart disease
- ☐ Convulsion/ epilepsy
- ☐ Cortisone medicine
- ☐ Crohn's disease
- ☐ Deaf
- ☐ Diabetes
- ☐ Digestive tract ulcer
- ☐ Ear ache
- ☐ Emphysema
- ☐ Excessive bleeding
- ☐ Fainting/ dizziness
- ☐ Genital herpes
- ☐ Glaucoma
- ☐ Gout
- ☐ Head injury
- ☐ Headaches
- ☐ Hearing problem
- ☐ Heart attack/ failure
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Heart valve problems
- ☐ Hepatic infection
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ History of drug abuse
- ☐ HIV positive
- ☐ Hives/ rash
- ☐ Implants_____
- _____
- ☐ Kidney problems
- ☐ Leukemia
- ☐ Liver disease
- ☐ Nervous disorder
- ☐ Nervous of dentist
- ☐ On dialysis
- ☐ Oral contraceptives
- ☐ Pacemaker
- ☐ Pain in the jaw joint
- ☐ Parathyroid disease
- ☐ Pneumonia
- ☐ Portal hypertension
- ☐ Prosthetic hip or joint
- ☐ Psychiatric care
- ☐ Recent blood transfusion
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Rheumatism
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sickle cell disease
- ☐ Skin sores/ blisters
- ☐ Stomach ulcers or colitis
- ☐ Stroke (year_____)
- ☐ Swelling of limbs
- ☐ Thyroid problem
- ☐ Trying to get pregnant
- ☐ Tuberculosis
- ☐ Tumor or growths
- ☐ Venereal disease
- ☐ Wheelchair patient
- ☐ Other_____
- ☐ _____

For Woman Only:

- ☐ Pregnant months_____
- ☐ Nursing
- ☐ Is there a chance you may be pregnant?

Reason for today's visit: _____

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

Do you have any Allergies? YES [ ] NO [ ]

- ☐ Acrylic
- ☐ Acetaminophen
- ☐ Amoxicillin
- ☐ Tylenol
- ☐ Latex
- ☐ Aspirin
- ☐ Penicillin
- ☐ Vicodin
- ☐ Motrin
- ☐ Lidocaine
- ☐ Codeine
- ☐ Epinephrine
- ☐ Metal; type_____
- ☐ Ibuprofen
- ☐ Sulfa
- ☐ Other

Are you taking any of the following? YES [ ] NO [ ]

[ ] Aspirin/Blood thinners [ ] Bisphosphonate Reason: _____

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

Date of last physical exam _____ Are you now under a physician's care for a particular problem? _____ Have you ever had any serious illness/ operation or hospitalization? _____ Due to pre-existing medical conditions, is pre-medication required for dental treatment? *If yes, please specify medication and its instructions*

_____ Please list all medications you are currently taking also including (Vitamin Supplements):_____

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_____