GRASSI & GRASSI P.C.
practice limited to endodontics

MEDICAL HISTORY RECORD

Today's Date: _____ Dentist Name: _____ Physician Name: _____

Patient Information

Name: _____ (Last / First / M.I.) S.S.#: _____

Email: _____ Date of Birth: _____

Address: _____ (Number and Street) Home Phone: _____

_____ (City / State / Zip) Cell Phone: _____

Employer: _____ Work Phone: _____

Marital Status: _____ Spouse/ Partner Name: _____

Person Responsible for Payment

☐ *Same as above (If so, leave this section blank)*

Name: _____ (Last / First / M.I.) S.S.#: _____

Email: _____ Date of Birth: _____

Address: _____ (Number and Street) Home Phone: _____

_____ (City / State / Zip) Cell Phone: _____

Employer: _____ Work Phone: _____

Relationship to Patient: _____

Dental Insurance

	Primary Dental Insurance	Secondary Dental Insurance (if applicable)
Insured Name:	_____ (Last / First / M.I.)	_____ (Last / First / M.I.)
Insured Birthdate:		
Employer:		
Group # / ID #:	_____ / _____ (Group # / ID #)	_____ / _____ (Group # / ID #)
Insurance Name:		
Insurance Address:		

For Office Use Only	Name: _____ (Last, First M.I.)	_____ (Date of Birth)

Please respond to each of the following questions:

☐ Yes ☐ No Are you in good health now?

☐ Yes ☐ No Are you under the care of a physician?
If so, what is the condition being treated? _____

☐ Yes ☐ No Have you ever been hospitalized or had a serious illness?
If yes, explain: _____

☐ Yes ☐ No Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?

☐ Yes ☐ No (Women) Are you pregnant? If so, what is your due date? _____

☐ Yes ☐ No (Women) Are you on birth control pills?
(If so, you should use an additional form of birth control while on antibiotics)

Are you allergic to any of the following?

☐ Yes ☐ No	Local Anesthetics (e.g., Novocaine)	☐ Yes ☐ No	Aspirin
☐ Yes ☐ No	Barbiturates, Seditives/sleeping pills	☐ Yes ☐ No	Codeine
☐ Yes ☐ No	Penicillin	☐ Yes ☐ No	Sulfa Drugs
☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No	Erythromycin
☐ Yes ☐ No	Other Allergies? Explain:	☐ Yes ☐ No	Latex

_____

Are you currently taking:

☐ Yes ☐ No Blood Thinners (ex: Coumadin, Warfarin, Pradaxa)

☐ Yes ☐ No Bisphosphonates (ex: Fosamax, Boniva, Reclast, Actone, Zometa)

Do you need to pre-medicate before a dental procedure? If so, explain below:

☐ Yes ☐ No _____

_____

_____

Please list all prescription and non-prescription drugs you are currently taking.

_____

_____

_____

Pharmacy Name: _____ Location: _____ Phone: _____

For Office Use Only	Name: _____ Last, First M.I.	_____ Date of Birth

Do you currently have (or previously had) any of the following?

☐Yes	☐No	Persistent fever	☐Yes	☐No	Rheumatic fever
☐Yes	☐No	Eruptions (rash) hives	☐Yes	☐No	Heart murmur
☐Yes	☐No	Glaucoma	☐Yes	☐No	Chest pain/discomfort
☐Yes	☐No	Loss of hearing	☐Yes	☐No	Heart attack/trouble
☐Yes	☐No	Ringing in ears	☐Yes	☐No	High blood pressure
☐Yes	☐No	Frequent nosebleeds	☐Yes	☐No	Congenital heart disease
☐Yes	☐No	Sinus problems	☐Yes	☐No	Mitral valve prolapse
☐Yes	☐No	Stroke	☐Yes	☐No	Artificial heart valve
☐Yes	☐No	Convulsions/epilepsy	☐Yes	☐No	Pacemaker
☐Yes	☐No	Dizziness/fainting	☐Yes	☐No	Heart surgery
☐Yes	☐No	Psychiatric treatment	☐Yes	☐No	Taking anticoagulants
☐Yes	☐No	Tuberculosis	☐Yes	☐No	Other heart problems
☐Yes	☐No	Emphysema	☐Yes	☐No	Arthritis/rheumatism
☐Yes	☐No	Asthma/hay fever	☐Yes	☐No	Artificial joints
☐Yes	☐No	Diabetes	☐Yes	☐No	Implant/graft surgery
☐Yes	☐No	Thyroid condition/goiter	☐Yes	☐No	Venereal disease
☐Yes	☐No	Swelling of ankles	☐Yes	☐No	Bruise easily
☐Yes	☐No	Hepatitis	☐Yes	☐No	Blood transfusion
☐Yes	☐No	Jaundice	☐Yes	☐No	Radiation therapy
☐Yes	☐No	Kidney disease	☐Yes	☐No	Tumors or growths
☐Yes	☐No	Shortness of breath	☐Yes	☐No	Cancer
☐Yes	☐No	Drug/alcohol addiction	☐Yes	☐No	AIDS/HIV+

Is there any disease, condition, or problem not listed above that you think we should know about or is there any activity your doctor says you cannot do? If so, please explain:

_____

_____

_____

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 change in my medication, I will inform the dentist at the next appointment.

In case of emergency, contact: _____ Phone: _____

Signature of patient, parent, or guardian: _____ Date: _____

Doctor's signature: _____ Date: _____