GUIDING YOU TOWARD DENTAL HEALTH
COMPASS DENTAL

Medical & Dental History From

Patient name: _____ _____
First, MI, Last Preferred Name

SSN # _____ - _____ - _____ **Driver's License#**_____ **Email:** _____

Date of Birth: _____ - _____ - _____ **Male** ____ **Female** ____ **Marital Status** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Telephone: Home: _____ **Cell:** _____ **Work:** _____

Place of employment: _____

Emergency Contact (Name and phone#):_____

To ensure the quality of your care, please state your purpose for coming to Compass Dental today.

_____

How did you hear about Compass Dental: _____

Primary Dental Insurance:

If you have dental insurance, please present your card to the front desk.

Policy Holder Name: _____ _____ _____
Last MI First

Policy Holder's Date of Birth: _____ **SSN:** _____ **Group #:** _____

Insurance Provider: _____**Policy Holder's Employer Name:** _____

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Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Please indicate if you have experienced any of the following

☐ Allergy- Aspirin	☐ Allergy-Codeine	☐ Allergy-Erythro	☐ Allergy-Hay Fever
☐ Allergy-Latex	☐ Allergy-Milk	☐ Allergy-Penicillin	☐ Allergy-Sulfa
☐ Anemia	☐ Anti- Depressants	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Bisphosphonates	☐ Blood Disease	☐ Blood Thinner
☐ Cancer	☐ Contraception	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Gag Reflex
☐ Ulcers	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol	☐ HIV
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders	☐ Nervous
☐ Nervous Disorders	☐ Pacemaker	☐ Radiation Treatment	☐ Respiratory Problems
☐ Seizures	☐ Sinus Problems	☐ Tobacco	☐ Tuberculosis
☐ Stomach Problems	☐ Stroke	☐ Tumors	☐ Other

Are you allergic to or do you suffer ill effects from any of the additional items:

☐ Household Bleach ☐ Dental Anesthesia ☐ Other _____

Do you have any other health issues or allergies?

Please mark any of the following to indicate yes in response to the question:

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions marked, please explain:
(Example: Hip/Knee replacement; Heart Stint/By-Pass etc.)

Your Primary Care Physician's name: _____

Preferred Pharmacy: _____

Are you currently taking any prescriptions or non-prescription medications? If so, please list all medications below:

Please indicate with an "X" below if you are currently taking the following OR with a "/" if you have taken it in the past.

- ☐ Anticoagulants
- ☐ Cortisone Drugs
- ☐ Hormone Therapy
- ☐ Medications for Osteoporosis
- ☐ Sedatives
- ☐ Steroids
- ☐ Tranquilizers

WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No If yes, when is the due date: _____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

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AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for the remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or my dependents (if any).

Signature of patient, parent, or guardian:

_____ _____

Signature Date

Relationship to Patient: _____

Responsible Party: _____