Mint Condition Dental

Thank you for choosing our office to assist you with your dental needs. Please fill out the information below.

Patient's name ____ Date of Birth: ________________ Sex:___________
If minor, name of legal guardian______________________________________ Home phone: _____________________
Mobile phone :_____________________ Work Phone: __________________ Email: ___________________________
Mailing address: ____ Apt/Unit#:______________________
City _______________________ State ________________ Zip _____________
Employer _____________________Whom may we thank for referring you to our office? _____________________
INSURANCE INFORMATION: ☐Not covered by dental insurance
Your SS#: ______________________ Member ID#____
Dental Insurance Co. ______________________________ Group number_______________________
Covered by secondary insurance? ☐ yes ☐ no
Subscriber's Name __________________________________ Subscriber's SS# _________________________
Subscriber's dental insurance company ________________________ Group number ___________________
Subscriber's Date of Birth _______________________ Subscriber's member ID# _______________________

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following? (Please check any that apply)

☐ **Are you required to Pre-medicate before any dental treatment?**

☐ Blood Problems (Anemia)
☐ Blood transfusion
☐ Heart problems
☐ Heart murmur, mitral valve prolapse, heart defect
☐ Heart Pacemaker
☐ Stroke
☐ Bone or joint problems
☐ Artificial joint or valves
☐ High or low blood pressure (circle one)
☐ Tuberculosis or other lung problems
☐ Kidney disease
☐ Hepatitis, jaundice or other liver disease
☐ Diabetes TYPE 1 or TYPE 2 ☐Hypoglycemic
☐ Epilepsy or Neurological disorders
☐ Thyroid problems
☐ Arthritis
☐ Herpes or cold sores
☐ AIDS or HIV positive
☐ Cancer/Tumor
☐ Abnormal bleeding after any surgery
☐ Hay fever or sinus trouble
☐ Allergies ☐ Asthma
☐ Sleep Apnea

Surgical History:

_______________________ Date: __________________
_______________________ Date: __________________
_______________________ Date: __________________
*Please write on back for additional surgeries

Are you allergic to, or have you reacted adversely to any of the following?

☐ Latex
☐ Penicillin or other antibiotics
☐ Local anesthetics
☐ Codeine or other narcotics
☐ Sulfa drugs
☐ Barbiturates, sedatives, or sleeping pills
☐ Aspirin
☐ Other:____________________________

Are you taking any of the following?

☐ Aspirin
☐ Anticoagulants (blood thinners)
☐ Antibiotics or sulfa drugs
☐ High blood pressure medicine
☐ Antidepressants or tranquilizers
☐ Insulin/other diabetes drugs
☐ Nitroglycerin
☐ Cortisone or other steroids
☐ Osteoporosis (bone density) medicine
☐ Natural supplements
☐ Other:___________________________

☐ *** To the best of my knowledge, all the proceeding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental visit.**

Women:

☐ Are you pregnant or plan to become pregnant
☐ Taking hormones or contraceptives

Do you smoke, vape or use tobacco? yes ☐ no ☐

Name of your primary medical physician: __________________________ **Phone number**___________________________
Signature of patient (or parent): ____ **Date:** ___________________________
MCD Provider Signature: ____ **Date:** ___________________________