



JEFF MONTGOMERY DDS
General & Cosmetic Dentistry

Patient Name: _____ Preferred Name: _____

Address: _____

Date of Birth: _____ SSN: _____ Sex: Male / Female

Home Phone: _____ Cell Phone: _____

Email: _____

How did you hear about our office? _____

Emergency Contact: _____ Phone: _____

Primary Physican: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Dental Insurance Information

Insurance company: _____

Is this through an Employer? NO YES Employer: _____

Relationship to patient: _____ *(If self, you do not need to fill out the next line.)*

Policy Holder Name: _____

Date of Birth: _____ SSN: _____

Please, notify the front desk if you have secondary insurance.

For women only:

Are you pregnant?	<input type="checkbox"/> NO	<input type="checkbox"/> YES, # of weeks _____
Are you nursing?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Are you taking birth control pills?	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Please list any medications you are taking: _____

Please, check any medical conditions that you have or had:

<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Head/Neck Pain	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> STD
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Shingles
<input type="checkbox"/> Cancer or Chemo	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Colitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> HIV /AIDS	<input type="checkbox"/> Snore
<input type="checkbox"/> Dementia / Alzheimer's	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Stomach Trouble
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Taking blood thinner
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Drug or Alcohol Use	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Nervousness	
<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Pain in Jaw Joints	

Please, check any medical allergies: NONE

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Barbiturates or sedatives	<input type="checkbox"/> Jewelry	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Latex	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dental anesthetics	<input type="checkbox"/> Metals	

Is there anything else we should know about your health that was not covered by this form?

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health or medication changes, I will inform my dentist at my next appointment.

Signature of Patient or Guardian _____ **Date** _____

Medical History Update <i>*To be signed at your next appointment*</i>		
Date: _____	Date: _____	Date: _____