Medical History

SUTTON DENTISTRY
2825 S.E. 17th Street
Ocala, FL 34471

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ ☐ Single ☐ Married ☐ Child ☐ Other_____ Birth Date: _____

Social Security #: _____ DL# _____

Phone (Home): _____ (Work): _____ (Cell):_____

Email Address:_____ Preferred method of correspondence (select all that apply): ☐ Call ☐ Text ☐ Email

Address: _____
Street Apartment #

_____
City State Zip Code

Do any members of your immediate family come to our practice?_____

Employer Name: _____ Occupation: _____

Spouse's Name:_____ Spouse's Employer:_____

Closest Relative not living with you:_____Phone: _____

Address:_____

If child is a minor, please complete the following:

Guardian/Parents Name: _____

Social Security #_____DL# _____

Address if different from Child: _____

Dental Insurance Information

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

_____

Referral Information

Whom may we thank for referring you to our practice? _____

Another patient, friend Another patient, relative Dental Office Yellow Pages Newspaper School Work

Other_____

PLEASE COMPLETE OTHER SIDE

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____

Please answer the following?

☐ Yes ☐ No Heart Valve Replacement If yes, date of surgery_____

☐ Yes ☐ No Artificial Joint Replacement If yes, date of surgery_____

☐ Yes ☐ No Premedicate for dental procedures
Dr. Name and Phone Number_____

☐ Yes ☐ No Have you ever taken any Osteoporosis Medications/Bisphosphonates? If yes, please list_____
i.e. Denosumab (Prolia), Ibandronate(Boniva), Alendronate(Fosamax), Risedronate (Actonel), Zolendronic Acid (Reclast)

☐ Yes ☐ No Are you currently taking any blood thinners? If yes, please list_____
i.e. Coumadin (Warfarin), Pradaxa (Dabigatran), Eliquis (Apixaban), Heparin, Xarelto

☐ Yes ☐ No Are you allergic to any antibiotics? If yes, please list_____
i.e. Penicillin, amoxicillin, azithromycin, doxycycline, cephalexin, ciprofloxacin, clindamycin, Keflex

☐ Yes ☐ No Are you currently on a pain management program?

☐ Yes ☐ No Are you currently pregnant?

Which Pharmacy do you prefer?

Pharmacy Name/Location? _____ Phone: _____

Have you ever had any of the following? Please check those that apply:

☐ Alzheimer
☐ Allergy: Codeine
☐ Allergy: Latex
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer:_____
☐ COPD
☐ Codeine Allergy
☐ Diabetes Type:_____
☐ Dementia
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis:_____
☐ Herpes
☐ HIV and/or AIDS
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders:
_____
☐ Nervous System Disorder:
_____
☐ Pacemaker
☐ PTSD
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Smoking/Tobacco
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Other (not listed):
_____
_____
_____

ALLERGIES/OTHER:
_____
_____
_____
_____

MEDICATIONS:
(PLEASE PROVIDE LIST)
_____
_____
_____
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date:_____
Signature of Patient, parent or guardian

_____ Date: _____
Signature of Doctor