SUGARLOAF DENTAL
Since 1973

James B Reid, D.D.S.
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Jared J. Reid, D.M.D.

4 Park Street, South Deerfield, MA 01373 413 665-4575

PATIENT MEDICAL DENTAL HISTORY

PATIENT LAST NAME_____ FIRST_____ INITIAL_____ DOB____/____/____ Male ❑ / Female ❑

STREET_____ TOWN_____ STATE_____ ZIP_____

MEDICAL HISTORY

Date of last medical physical exam_____

Physician's name_____

address_____

_____

Are you under a physician's care for a particular problem? Yes ❑ / No ❑

If yes, for what reason?_____

Please list any medications you are taking;_____

_____

_____

Are you alergic to, or have you had, any adverse reaction to any medication or latex products? Yes ❑ / No ❑

If yes, what?_____

Do you have an artificial joint or heart valve implant? Yes ❑ / No ❑

Have you been treated for, or been told you might have heart disease?

Yes ❑ / No ❑ If yes, what?_____

Have you ever had rheumatic fever? Yes ❑ / No ❑

Do you have AIDS? Yes ❑ / No ❑

Do you have HIV infection? Yes ❑ / No ❑

Is your blood pressure high ❑ / low ❑ / normal ❑ ? S_____D_____

Have you ever bled excessively after bing cut or injured? Yes ❑ / No ❑

Are you diabetic? Yes ❑ / No ❑

Circle any and all of the following which you have had or have now;

Heart Disease or Attack	Hepatitis B (serum)
Angina Pectoris	Liver Disease
High Blood Pressure	Yellow Jaundice
Heart Murmur	Hemophilia
Rheumatic Fever	Venereal Disease
Congenital Heart Lesions	(syphilis, Gonorrhea)
Scarlet Fever	Cold Sores
Artificial Heart Valve	Genital Herpes
Heart Pacemaker	Epilepsy or Seizures
Heart Surgery	Fainting
Artificial Joint	Dizzy Spells
Anemia	Diabetes
Stroke	Thuyroid Disease
Tuberculosis (TB)	X-ray or Cobalt Treatment
Asthma	Chemotherapy
Hay Fever	Cancer, Lukemia
Sinus Trouble	Arthritis
Emphysema	Rheumatism
AIDS	Cortisone Medication
Hepatitis A (infectious)	Glaucoma
Hepatitis C or non A/B	Pain in Your Jaw Joints

WOMEN -

Are you pregnant now? Yes ❑ / No ❑

CHILDREN -

Is child; receiving fluoride vitamins or drops? Yes ❑ / No ❑, a mouth breather? Yes ❑ / No ❑, having any thumb or finger habits? Yes ❑ / No ❑

Is there anything else we should know about your (the patient's) health? Yes ❑ / No ❑ If so what?_____

_____

I certify that the above information is complete and accurate

Signature of Patient / Parent / Guardian _____ Date_____

Patient please complete other side.....

MEDICAL UPDATE

CONDITION	DATE	MEDICATIONS	DOSAGE	DATE OF CHANGE

MED ALERT

Anest.

BILLING INFORMATION (person responsible for payment)

NAME_____

STREET_____

TOWN_____ STATE_____ ZIP_____

HOME PHONE_____

WORK PHONE_____

SPOUCE'S NAME_____

SPOUCE'S ADDRESS IF DIFFERENT;

STREET_____

TOWN_____ STATE_____ ZIP_____

HOME PHONE_____

WORK PHONE_____

REFERRED BY_____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING;

INSURED PERSON_____

DOB_____SS#_____

ADDRESS IF DIFFERENT THAN ABOVE;

STREET_____

TOWN_____ STATE_____ ZIP_____

EMPLOYER NAME_____

EMPLOYER ADDRESS_____

INSURANCE COMPANY NAME_____

INSURANCE ID NUMBER_____

INSURANCE GROUP NUMBER_____

ARE YOU COVERED UNDER ANY OTHER DENTAL INSURANCE? Yes ❑ / No ❑

IF SO COMPLE THE FOLLOWING;

INSURED PERSON_____

DOB_____SS#_____

EMPLOYER NAME_____

INSURANCE COMPANY NAME_____

INSURANCE COMPANY ID#_____

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