



SUGARLOAF DENTAL

James B Reid, D.D.S.
Robert M. Klenowski, D.D.S.
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 allergic 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 being 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

Angina Pectoris

High Blood Pressure

Heart Murmur

Rheumatic Fever

Congenital Heart Lesions

Scarlet Fever

Artificial Heart Valve

Heart Pacemaker

Heart Surgery

Artificial Joint

Anemia

Stroke

Tuberculosis (TB)

Asthma

Hay Fever

Sinus Trouble

Emphysema

AIDS

Hepatitis A (infectious)

Hepatitis C or non A/B

Hepatitis B (serum)

Liver Disease

Yellow Jaundice

Hemophilia

Venereal Disease

(syphilis, Gonorrhea)

Cold Sores

Genital Herpes

Epilepsy or Seizures

Fainting

Dizzy Spells

Diabetes

Thyroid Disease

X-ray or Cobalt Treatment

Chemotherapy

Cancer, Lukemia

Arthritis

Rheumatism

Cortisone Medication

Glaucoma

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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