What is the reason for your visit today?_____

Name: _____ Chart _____

DOB _____ Age_____ **Height**_____ **Weight**_____

General Dentist:_____Pysician_____

Office Use Only

BP:_____HR:_____

Sa02:_____MP:_____

BMI:_____ASA:_____

Patient Health History • Please check all that apply:

Brain / Neurological
- Fainting
- Alzheimer's
- Brain Injury
- Hydrocephalus / VP Shunt
- Multiple Sclerosis
- Parkinson's
- Seizure/Epilepsy
- Stroke / TIA

Heart / Cardiovascular
- Birth/Congenital Defects
- High Blood Pressure
- Angina/Chest Pain
- Heart Attack/MI
- Coronary Artery Stents
- Heart Bypass Grafts
- Irregular Beats Artificial Valve
- Pacemaker/Defibrillation
- Heart Transplant

Hormone / Endocrine
- Diabetes
- Insulin Resistance
- Pituitary Disorder
- Thyroid Disorder
- Parathyroid Disorder
- Pancreas Disorder
- Adrenal Disorder

Blood / Immunity
- Cancer
- Leukemia
- Hepatitis
- HIV/AIDS
- Anemia
- Tuberculosis
- Night Sweats
- Bleeding Disorder
- Chemotherapy/Radiation
- Sexually Transmitted Disease
- Immune Deficiency

Lungs / Pulmonary
- Snoring / Sleep Apnea
- CPAP Use
- Oxygen Use
- Asthma
- Short of Breath
- COPD / Emphysema
- Chronic Bronchitis
- ARDS /Pneumonia
- Pulmonary Hypertension

Stomach / Gastrointestinal
- Vomiting
- Acid Reflex
- Jaundice
- Gall Stone
- Liver Disease
- Crohn's Disease
- Ulcerative Colitis
- Bariatric Surgery
- Diarrhea/Constipation
- Nutritional Disorder
- Dieting

Kidney / Urinary Tract
- Kidney Stones
- Kidney Failure
- Dialysis
- Kidney Transplant
- Bladder Disorder/ Infection
- Recurrent Kidney/ Infections

Bones / Musculoskeletal
- Arthritis
- Osteoporosis
- Osteomyelitis
- Neck Disorders
- Rheumatoid Diseases
- Radiation to Jaws /FME
- Kyphosis / Scoliosis
- Malignant Hyperthermia
- Myasthenia Gravis/Muscle Disorder

Mental / Psychological
- Anxiety
- Depression
- Bipolar
- ADD/ADHD
- Schizophrenia
- Anorexia / Bulimia
- Current Counseling

Have You Ever or Are You Now Taking Bisphosphonate Medication
- Zometa ☐ Reclast
- Aredia ☐ Boniva
- Fosamax ☐ Actonel
- Didronel ☐ Aclasta

☐ Denosumab/ Prolia

Social Habits
- Smoke Tobacco
- Smokeless Tobacco
- Alcohol
- Street Drugs
- Herbs
- Diet Pills

Women
- Pregnant
- Nursing/Lactating
- Birth Control Pills
- Depo-Provera Shots
- Nova Ring

List Drug /Food Allergies

_____

_____

List current medications

_____

_____

_____

List past surgeries w/ dates

_____

_____

Certification and Signature

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I certify that the information I have provided above is true and correct to the best of my knowledge. I will not hold Dr. Gregory McGee responsible for any errors or omissions that I may have made in completing this form.

Signature of Patient **X**_____

Or Parent or Guardian if under age 18

Date _____

Chart No._____

Patient Information **Please complete** all questions

Patient Name _____

Birth Date_____ Male Female

Soc Sec or Idaho Driver Lic No..._____

Address _____

City _____

State _____ Zip _____

Home Phone _____Cell _____

E-Mail _____

Occupation _____

Employer_____ Phone _____

Spouse's Name _____

Single Married Widowed Minor

Person Responsible for Account

Self___ (continue to next section)

Spouse___ Parent___ Stepparent___ Other___

Name_____DOB_____

Address_____

_____

Phone:_____ Wrk Phone:_____

Employer:_____

Does the patient, if a minor reside with this person? Yes / No
Does this person carry the Primary insurance plan? Yes / No

◊ Emergency Contacts ◊

Name:_____

Relationship:_____Phone_____

Did someone Recommend our office to you?

Dentist Prior Patient Friens / Family

Name_____

Insurance (*Please provide Insurance cards*)

Insurance companies require the policyholder's birthdate and address for claim processing. If the primary insured is different than the *Patient,* or *Responsible Person* shown on form, please complete all applicable information below.

Dental insurance

Policyholder's Date of Birth._____

Name _____

Address_____

_____Phone _____

ID #_____ Group #_____

Insurance Company_____

Is patient covered by another Dental plan? Yes / No

Medical insurance

Policyholder's Date of Birth_____

Name_____

Address_____

ID # _____Group #_____

Insurance Company_____

Is patient covered by another Medical plan? Yes / No

Secondary Medical or Dental Insurance

Policyholder's date of Birth _____
Name _____
Address _____
Insurance Company _____
ID# _____ Grp _____

Assignment, and Release

I authorize my insurance benefits to be paid directly to the provider, Gregory McGee, D.M.D.. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. **Intial**_____

Gregory McGee, D.M.D, may use my health information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or two years from the date signed below. **Initial**_____

X_____ _____ **X**_____ _____
Patient Date Responsible Party Date