

# Adult Medical History

CIGNA Dental



Please complete Dental History Information on reverse side.

| PATIENT INFORMATION                               |   |  |           |
|---|---|--|-----------|
| PATIENT'S NAME (Last, First, M.I.)                |   | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE |
| SOCIAL SECURITY NO.                               | IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME |  | AGE       |
| WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? |   | REASON FOR THAT VISIT  |           |
| PHYSICIAN NAME                                    | PHYSICIAN ADDRESS                                       | PHYSICIAN PHONE NUMBER                                       |           |

| RESPONSIBLE PARTY INFORMATION           |            |                      |                     |
|---|------------|----------------------|---------------------|
| NAME (Last, First, M.I.)                |            |                      | MARITAL STATUS      |
| ADDRESS (Street, City, State, Zip Code) |            |                      |                     |
| HOW LONG AT THIS ADDRESS                | HOME PHONE | WORK PHONE           |                     |
| SOCIAL SECURITY NO.                     | BIRTH DATE | DRIVER'S LICENSE NO. | RELATION TO PATIENT |
| EMPLOYER                                | OCCUPATION |                      | NO. YEARS EMPLOYED  |

| RESPONSIBLE PARTY'S SPOUSE |            |           |                     |
|----------------------------|------------|-----------|---------------------|
| NAME (Last, First, M.I.)   |            |           | SOCIAL SECURITY NO. |
| EMPLOYER                   | OCCUPATION |           |                     |
| NO. YEARS EMPLOYED         | WORK PHONE | BIRTHDATE |                     |

| UPDATES |               |      |               |
|---------|---------------|------|---------------|
| DATE    | DR. SIGNATURE | DATE | DR. SIGNATURE |

**MEDICAL HISTORY** - Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE THE FOLLOWING, if yes, please indicate "yes" and circle illness:

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Asthma, hay fever sinusitis, or other allergies  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Allergy to penicillin, aspirin, local or general anesthetic, or other drugs; specify:                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Blood pressure or heart problems   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Rheumatic fever or heart murmur or mitral valve prolapse   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. A pacemaker or open heart surgery or heart valve replacement   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes, liver, kidney, thyroid or lung problems  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ulcer or stomach problems  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hepatitis or Jaundice  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Eplilepsy or nervous disorders   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Bleeding or clotting disorders  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Arthritis or hip replacement surgery or prosthetic joint replacement  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Communicable disease: tuberculosis, herpes or venereal  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Acquired Immune Deficiency Syndrome (AIDS) / A.R.C. / HIV Positive  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Any other illness   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do any wounds heal slowly or present complications?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are you presently taking any medicine? Specify:   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you presently under the care of a physician?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. When was your last physical exam? _____/_____/_____   |                          |                          |
| 19. Have you ever been hospitalized? Date: _____/_____/_____ Reason:  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had X-ray treatments or chemotherapy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you presently on a diet?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Women <input type="checkbox"/> Are you taking birth control pills? <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

|                   |      |               |      |
|-------------------|------|---------------|------|
| PATIENT SIGNATURE | DATE | DR. SIGNATURE | DATE |
|-------------------|------|---------------|------|



Please complete Medical History Information on reverse side.

| DENTAL INSURANCE INFORMATION (Primary Carrier) |           |           |
|--|-----------|-----------|
| INSURED'S NAME                                 |           |           |
| INSURANCE COMPANY                              |           |           |
| INSURANCE COMPANY ADDRESS                      |           |           |
| INSURED'S EMPLOYER                             |           |           |
| INSURED'S SOCIAL SECURITY NO.                  | GROUP NO. | LOCAL NO. |

| DATE OF LAST DENTAL EXAM   | DATE OF LAST FULL MOUTH X-RAY | WHERE TAKEN  |  |                          |                          |
|--|-------------------------------|--|--|--------------------------|--------------------------|
|  |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><b>YES</b></td> <td style="text-align: center; padding: 0 10px;"><b>NO</b></td> </tr> </table>                              |  | <b>YES</b>               | <b>NO</b>                |
|  | <b>YES</b>                    | <b>NO</b>  |  |                          |                          |
| 1. Have you had trouble from previous dental care?   |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 2. Do you have pain in your jaw or near your ears?   |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 3. Do you have any unhealed injuries or inflamed areas in or around your mouth?                    |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 4. Have you experienced any growths or sore spots in your mouth?                                   |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 5. Does any part of your mouth hurt when clenched?   |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 6. Have you ever had Novocaine or other local anesthetic?  |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 7. Have you ever had Nitrous Oxide (laughing gas)?   |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 8. Have you ever had general anesthesia?   |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 9. Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics? |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 10. Have you ever had any difficult extractions in the past?                                       |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 11. Have you ever had prolonged bleeding following extractions in the past?                        |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 12. Do your gums bleed?  |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 13. Do you have a bad taste in your mouth or mouth odor?   |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 14. Have you ever had instructions on the care of your gums?                                       |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 15. Do you chew on only one side of your mouth? If so, why?  |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 16. Do you habitually clench or grind your teeth during the night or day?                          |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| 17. Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?           |                               | <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table> |  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/>      | <input type="checkbox"/>   |  |                          |                          |
| Is there any other problem not covered above that you would like to discuss?                       |                               |  |  |                          |                          |
|  |                               |  |  |                          |                          |
|  |                               |  |  |                          |                          |

\*I authorize CIGNA Dental or any participating dental office to release my dental records to any CIGNA Company for plan administration purposes.

|                    |      |               |      |
|--------------------|------|---------------|------|
| *PATIENT SIGNATURE | DATE | DR. SIGNATURE | DATE |
|--------------------|------|---------------|------|