

Date _____

MEDICAL HISTORY FORM

Patient Information:

Patient's Name: _____
Last First Middle Initial

Address: _____
Address City State Zip Code

Email Address: _____ SSN: _____ - _____ - _____ Date of Birth: ____/____/____ Age: ____

Sex: M F Home No: _____ Cell No: _____ Alt. No: _____

Parent/Guardian Insurance Information: Relationship to Patient: _____ SELF

Name: _____
Last First Middle Initial

SSN: _____ - _____ - _____ Insurance No.: _____ Driver License No.: _____

Date of Birth: ____/____/____ Insurance Telephone No.: _____ Group No.: _____

Employer: _____ Address: _____

Home No: _____ Cell No: _____ Work No: _____

Name and Number of nearest relative not living with you: _____

How did you hear about us? Please mark below:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Online | <input type="checkbox"/> Flyer / Mail | <input type="checkbox"/> Printed Ad | <input type="checkbox"/> Billboard |
| <input type="checkbox"/> Radio | <input type="checkbox"/> TV | <input type="checkbox"/> Community Event | <input type="checkbox"/> Health Fair / Screening |
| <input type="checkbox"/> Dr. Referral | <input type="checkbox"/> Driving / Walking by the Office | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Insurance / Employer |
| <input type="checkbox"/> Friend / Relative | <input type="checkbox"/> Employee | <input type="checkbox"/> Other (Specify) _____ | |

Reason for today's dental visit: _____ Date of last dental visit: _____

Have you ever had an experience in a dental office that you would like to tell us about? Yes No

Please explain if yes: _____

Are you nervous about dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do your gums bleed, feel tender or irritated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you unhappy with appearance of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are your teeth sensitive? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have discolored teeth that bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, to what? Sweets Hot Cold Pressure

Are you now seeing a physician? Yes No The name & telephone number of your physician(s) _____

If so, what is the condition being treated? _____

Are you taking any medications? Yes No If yes, please list: _____

Have you or are you currently taking Aspirin? Yes No

Do you use tobacco? Yes No If yes, what kind and how much? _____

Do you drink alcohol? Yes No If yes, how many units per week? _____

If female, are you or do you suspect to be pregnant? Yes No Months: _____

Have you or are you currently taking oral Bisphosphates? Actonel Boniva Fosamax Skelid Didrone Other _____

Have you had any joint replacements? Yes No If yes, when? _____

Is there anything else we should know about your health that was not covered on this form? Yes No

If yes, Please explain: _____

Please mark any of the following which you have had or have at present: NONE

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervousness | <input type="checkbox"/> HIV + AIDS |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Chemo: (Cancer, Leukemia) | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Pain in Jaw Joint |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Glaucoma |

Please mark any of the following medical allergies: NONE

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> Fen-Phen |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other antibiotic: | <input type="checkbox"/> Barbiturates or sedatives | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Latex | <input type="checkbox"/> Other: _____ |

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change, I will inform my dentist at the next appointment.

Signature of Patient/Parent/Guardian _____

Medical History Update: _____

Dr. _____ Date _____

Dr. _____ Date _____

Dr. _____ Date _____