Medical History Form

Date _____

Patient Information

Patient's Name: _____
LAST FIRST MIDDLE INITIAL

Social Security Number _____ Sex: M F Date of Birth _____ Age _____

If Patient is a Minor, give Parent's or Guardian's Name _____

Responsible Party Information

Last Name _____ First _____ Middle _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Driver's License No. _____ Home Phone _____ Work Phone _____

Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ No. of Years Employed _____

Name/Address/Phone No. of nearest relative not living with you _____

_____

How did you hear about us? Please check below:

☐ Yellow Pages ☐ Friend / Relative ☐ Radio Ad. - Which Station? _____ ☐ Bill Board

☐ Sign ☐ Mail Coupon ☐ TV Ad. - Which Station? _____ ☐ Employer

☐ Employee ☐ Health Fairs / Screenings ☐ News Paper - Which one? _____ ☐ Other (Specify) _____

Reason for today's dental visit _____

Date of last dental visit _____ Reason _____

Have you ever had an experience in a dental office, that you would like to tell us about? YES NO If YES, please explain _____

_____

Are you apprehensive about dental treatment?	YES	NO	Are your teeth sensitive to hot, cold, sweets, pressure?	YES	NO
Do your gums bleed, feel tender or irritated?	YES	NO	Do you have discolored teeth that bother you	YES	NO
Are you now seeing a physician?	YES	NO	Are you unhappy with the appearance of your teeth?	YES	NO

If so, what is the condition being treated? _____

The Name & Address of my Physician (s) is _____

What medications are you taking now? _____

If female, are you pregnant? YES NO If yes, how long? _____

Mark any of the following which you have had or have at present:

☐ Heart Disease	☐ Heart Pacemaker	☐ Ulcers	☐ Thyroid Disease	☐ Glaucoma
☐ High Blood Pressure	☐ Diabetes	☐ Emphysema	☐ Chemo. (Cancer, Leukemia)	☐ Pain in Jaw Joints
☐ Blood Disease	☐ Scarlet Fever	☐ Tuberculosis	☐ Arthritis	☐ HIV+
☐ Rheumatic Fever	☐ Anemia	☐ Asthma	☐ Rheumatism	☐ Hepatitis
☐ Heart Murmur	☐ Kidney Trouble	☐ Hay Fever	☐ Cortisone Medicine	☐ Hemophilia
☐ Venereal Disease	☐ Epilepsy or Seizures	☐ Nervousness	☐ Sickle Cell Disease	☐ Bruise Easily

Mark any of the following medications you are allergic to:

☐ Local Anesthetics	☐ Penicillin or other antibiotic	☐ Sulfa Drugs
☐ Aspirin	☐ Codeine or other narcotics	☐ Barbiturates, sedatives, or sleeping pills
☐ Iodine	☐ Other _____	

MEDICAL HISTORY UPDATED:

_____ DR. DATE _____ DR. DATE _____ DR. DATE

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