Medical History Form **Date_____/_____/_____**

Name_____ Home Phone (_____) _____

Address_____ Work Phone (_____) _____

City _____State _____Zip Code _____ Cell Phone (_____) _____

Occupation _____ Sex M F Date of Birth ___/___/___ Height_____ Weight_____ Single____ Married _____

Social Security # _____-_____-_____ Name of Spouse _____ Closest Relative_____

Person to contact in an emergency _____Emergency Phone #_____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by_____ Other family members seen by us_____

Email: _____@_____

Please circle if you have or ever had any of the following diseases or problems:

Heart Condition	Angina	Hepatitis A B C D	Persistent Cough
Heart Attack	Shortness of Breath	HIV/AIDS	Swollen Neck Glands
Heart Murmur	Ankle Swelling	Sexually Transmitted Disease	Low Blood Pressure
Rheumatic Heart Disease/Fever	High Blood Pressure	Thyroid Problems	Psychological Disorders
Cardiovascular Disease	Cardiac Pacemaker	Respiratory Problems	Mental Health Problems
Damaged/Artificial Heart Valves	Bodily Implants (Hip/Knee)	Emphysema	Immune System Problems
Heart Defects	Sinus Trouble	Bronchitis	Abnormal Bleeding
Mitral Valve Prolapse	Asthma	Arthritis	Blood Transfusion
Coronary Insufficiency/ Occlusion	Hay Fever/ Allergies	Stomach Ulcer	Blood Disorder
Arteriosclerosis	Neurological Disease	Hyperacidity	Tumors/Growths
Stroke	Epilepsy/ Seizures	Kidney Trouble	Cancer
Chest Pain	Fainting Spells	Tuberculosis	Diabetes

For the following questions, circle ***yes*** *or* ***no***. Your answers are for our records only and will be considered confidential. Please note that during your Initial visit you will be asked some questions about your responses to this questionnaire and there may be more questions concerning your health.

1. Are you in good health?..... Yes No
2. Are you under the care of a physician now?.....Yes No
3. Has there been any change in your health in the last year?.....Yes No
   8. If so what condition is being treated? _____
4. The name and address of my physician(s) is _____
   _____
   Phone # (_____) _____
5. Have you had any serious illness, operation or hospitalization in the past 5 years?..... Yes No
   If so, what was the illness or condition _____
6. Are you taking any medicine(s) including non-prescription medicine?.....Yes No
   8. If so, what medications are you taking? _____
7. Do you smoke or use tobacco products? ..... Yes No

Women

8. Are you pregnant? ..... Yes No
9. Do you have any problems associated with your menstrual period? .....Yes No
10. Are you nursing? ..... Yes No
11. Are you taking birth control pills? ..... Yes No

12. Are you allergic or have you ever had an allergic reaction to:

a. Local anesthetics (e.g.: ***Novocain***)……	Yes	No
b. Penicillin, erythromycin, tetracycline, cephalosporin or any other antibiotics. ……	Yes	No
c. Sulfa drugs ……	Yes	No
d. Barbiturates, sedatives, or sleeping pills ……	Yes	No
e. Aspirin ……	Yes	No
f. Iodine, shellfish or seafood……..	Yes	No
g. Codeine or other narcotics ……	Yes	No
h. Latex rubber ……	Yes	No
i. Any metals such as: (silver, nickel etc.) ……	Yes	No

13. Do you have any disease, condition, or problem not listed above that you think I should know about ? Yes No
If so, explain_____
_____

14. Are you wearing contact lenses? …… Yes No

Dental History

Last dental visit _____Last full Set of X-rays _____ How is your dental health? Poor? Good? Excellent?
Chief Dental Complaint (Why are you here today?):_____
Have you ever had any serious trouble associated with any dental treatment? Y N If so, explain_____
_____

Please circle if you have or ever had any of the following dental conditions or problems:

Hot/Cold Sensitivity	TMJ Pain	Snoring	Crooked Teeth
Sweet Sensitivity	Clenching	Tiredness	Chipped Teeth
Biting Pain	Grinding	Sleepiness	Cracked Teeth
Tooth Throbbing	Headaches	Lack of Energy	Yellow Teeth
Bleeding Gums	Neck pains	Sleep Apnea	Stained Teeth
Gum Pain	Ear Aches	Bad Breath	Loose Teeth

Are you happy with the way your smile looks? Y N If not, what would you change? _____
_____
Are you interested in a whiter, brighter straighter, more youthful smile? Y N
Do you participate in any contact sports? Y N Do you have an athletic mouth guard to protect your teeth? Y N

Please rank the following in the order (#1 To #4) in which they would keep you from having dental treatment:

Fear of pain #_____ Missing work time #_____ Cost of treatment #_____ Lack of concern # _____

CONSENT

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold the doctor or any other member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form. The undersigned hereby authorizes the doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my (the patient's) dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I understand that as per the Federal Truth in Lending Act, any overdue balance over sixty days will be subject to a 1.5 percent monthly finance charge.

Patient's signature (Parent of Child)_____Date____/____/_____ Doctor's Signature_____

I understand where appropriate, credit reports may be obtained

To be completed by the doctor

Comments On Patient interview_____
_____
Significant findings from oral interview_____
_____
Dental Management considerations _____
_____

Date_____/_____/_____ Doctor's Signature_____

Medical History Update:

Date	Comments	Signature
_____/_____/_____	_____	_____