



TODAY'S DATE: _____

MEDICAL HISTORY FORM

Patient's Name: _____
Last First Middle

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

If Patient is a Minor, please provide Parent's or Guardian's Name: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Driver's License #: _____ Date of Birth: _____ Relationship to Patient: _____

Telephone #'s: Home (_____) _____ Cell (_____) _____ Work (_____) _____

Email Address: _____

Employer: _____ Occupation: _____

Name/Address/Phone of nearest relative not living with you: _____

How did you hear about us? Please check below:

- | | | | | |
|--|---------------------------------------|--------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Television | <input type="checkbox"/> Radio Ad | <input type="checkbox"/> Billboard | <input type="checkbox"/> Health Fair/Screenings |
| <input type="checkbox"/> Friend/Relative | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Mail Coupon | <input type="checkbox"/> Employer | <input type="checkbox"/> Sign |
| <input type="checkbox"/> Employee | <input type="checkbox"/> Other: _____ | | | |

Reason for today's visit: _____

Date of last dental visit: _____ Reason: _____

Have you 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 happy with the appearance of your teeth? YES NO |

If so, what is the condition being treated? _____

Name/Address/Phone Number of Physician: _____

What medications are you taking now? _____

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

MARK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

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

MARK ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

- | | | |
|--|---|--|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin or Other Antibiotic | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine or Other Narcotics | <input type="checkbox"/> Barbiturates Sedative or Sleeping Pills |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other: _____ | |

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

X
Patient/Parent/Guardian Signature

_____ Date

Doctor's Signature

_____ Date