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:

☐ Online ☐ Flyer / Mail ☐ Printed Ad ☐ Billboard
☐ Radio ☐ TV ☐ Community Event ☐ Health Fair / Screening
☐ Dr. Referral ☐ Driving / Walking by the Office ☐ Medicaid ☐ Insurance / Employer
☐ Friend / Relative ☐ Employee ☐ 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? ☐ Yes ☐ No
Do your gums bleed, feel tender or irritated? ☐ Yes ☐ No
Are you unhappy with appearance of your teeth? ☐ Yes ☐ No
Are your teeth sensitive? ☐ Yes ☐ No
Do you have discolored teeth that bother you? ☐ Yes ☐ No
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/are taken oral Bisphosphonates? ☐ Actonel ☐ Boniva ☐ Fosamax ☐ Skelif ☐ 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

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

Please mark any of the following medical allergies: ☐ NONE

☐ Local Anesthetics ☐ Penicillin ☐ Codeine or other narcotics ☐ Fen-Phen
☐ Aspirin ☐ Other antibiotic: ☐ Barbiturates or sedatives ☐ Other: __________
☐ Iodine ☐ Sulfa Drugs ☐ Latex ☐ Other: __________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in myhealth, 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