

MEDICAL HISTORY FORM

Date _____

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) _____ | |

Dentist Name _____ Date of last dental visit: _____

Reason for today's visit _____

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 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 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

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervousness | <input type="checkbox"/> HIV + AIDS | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Chemo: (Cancer, Leukemia) | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Dementia/
Alzheimer's |
| <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 | |

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 _____