Please have form completely filled out at time of appt.

(PLEASE PRINT)

PATIENT MEDICAL HISTORY

PATIENT COMPLETE ONLY THIS SIDE

Name _____ Age _____ Birth Date _____ Sex F M

Address _____ City _____ Zip Code _____ County _____

Phone (Area Code) ( ) _____ Work Phone (Area Code) ( ) _____ Drivers License No. _____

Employer _____ Occupation _____ Social Security No. _____

Marital Status _____ Spouse's Name _____ or (If Dependent) Parent's Name _____

Employer (of Guarantor) _____ Employer (of Spouse) _____

Whom may we thank for this referral? _____

Medical Doctor _____ Office Phone _____

Approximate Date of Last Physical _____ Results _____

Person to notify in case of emergency (outside home) _____ Phone _____

Are you under any medical treatment?	YES	NO
Are you taking any prescription or non-prescription medications	YES	NO
Are you allergic to any medication, local anesthetic or material resulting in hives, asthma, etc.?	YES	NO
Have you had any major operations?	YES	NO
Have any wounds healed slowly or presented complications after extraction such as prolonged bleeding?	YES	NO
Do you have a history of fainting?	YES	NO
Have you ever had a serious accident involving head injuries?	YES	NO
Have you had any radiation treatments (Other than diagnostic) to head or neck?	YES	NO
Do you have any artificial joints (knee, hip, etc)?	YES	NO
Do you use tobacco products?	YES	NO
Have you ever been treated for gum disease?	YES	NO
Do you have any reason to suspect you have been in contact with the AIDS virus?	YES	NO
Do you have well water?	YES	NO

Please explain any "YES" answers: _____

DO YOU HAVE OR HAVE YOUR EVER HAD

Heart Condition	YES	NO	Diabetes	YES	NO
High/Low Blood Pressure	YES	NO	Cortisone-Steroid Treatment	YES	NO
Do you have a pacemaker?	YES	NO	Respiratory Disease	YES	NO
Heart Murmur	YES	NO	Sinus Problems	YES	NO
Rheumatic Fever	YES	NO	Tuberculosis	YES	NO
Anemia	YES	NO	Asthma	YES	NO
Blood Transfusions	YES	NO	Hay Fever	YES	NO
Blood Disease	YES	NO	Kidney Trouble	YES	NO
Liver Disease	YES	NO	Arthritis	YES	NO
Hepatitis	YES	NO	Tumor or Malignancy	YES	NO
Jaundice	YES	NO	Scarlet Fever	YES	NO
Nervous Disorder	YES	NO	Sexually Transmitted Disease	YES	NO
Epilepsy	YES	NO	Are You Pregnant?	YES	NO
Ulcer	YES	NO	If yes, delivery date		
Stroke	YES	NO			

Medications Used: _____

Are you happy with appearance of teeth? _____

Date of last dental visit _____ Were x-rays taken at that time YES NO Were your teeth cleaned at that time YES NO Do you have an immediate dental problem YES ___ NO ___ If so, where does it bother you _____ When did it start _____ What type of discomfort: Throbbing ___ Constant ___ Dull ache ___ Hot & Cold ___ Are you interested in emergency treatment or should we arrange a complete exam? _____

CHILDREN AND ADOLESCENTS

Does your child have a favorite nick-name? _____ Is your child involved in any of the following programs: Speech therapy ___ Special Education ___ Physically Handicapped ___

Is this your child's first treatment visit in a dental office? Yes ___ No ___ Has your child been treated for any medical or emotional problems? _____

I acknowledge that the above information is correct to the best of my knowledge. I assume responsibility for the treatment of the above named patient and assume financial responsibility for such treatment.

Patient/Parent or Guardian's Signature | Relationship to Patient | Date | Receptionist's Signature Upon Completion