

Medical History Form

Date _____

Patient Information:

Patient's Name _____
Last First Middle
Social Security Number _____ Sex M F Date of Birth _____ Age _____

If Patient is a Minor, give Parent or Guardian's Name _____

Responsible Party Information:

Last Name _____ First _____ Middle _____ Marital Status: _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone _____ Cell Phone _____

Date of Birth _____ Relationship to Patient _____

Email: _____

Name/Address/Phone No. of nearest relative not living with you: _____

Reason for today's dental visit _____

Date of last dental visit: _____ Reason _____

Have you ever had an experience in a dental office which 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 seeing a physician? YES NO Are you happy with the appearance of your teeth? YES NO

If so, what is the condition being treated?

The Name & Address of your physician(s): _____

What medication are you taking now? _____

If female, are you pregnant? YES NO. If yes, how long? _____

How did you hear about us? Please circle below:

Telephone Book – Which one _____ Employee _____ Employer _____ Sign/Flyer
Friend/Relative Health Fair/Screening Other (Specify) _____

Circle any of the following which you have had or have at present:

ADD/ADHD	Diabetes	Heart Disease	Kidney Problems
Asthma	Anemia	Heart Murmur	Chemo (Cancer, Leukemia)
Autism	Bruise Easily	High Blood Pressure	Glaucoma
Hepatitis	Epilepsy or Seizure	Scarlet Fever	Rheumatism
HIV	Thyroid Disease	Emphysema	Tuberculosis
Heart Pacemaker	Osteoporosis	Other _____	

Circle any of the following you are allergic to:

Aspirin/Ibuprofen/Tylenol	Barbiturates, sedatives, or sleeping pills	Codeine or other narcotics	Local Anesthetic/Lidocaine
Latex	Penicillin or other antibiotics	Sulfa Drugs	Other _____

I have answer all the above to the best of my knowledge. If I have any changes to my health or any changes to my medication, I will inform my dentist during my next appointment.

Signature of Patient / Parent / Guardian

-----**FOR OFFICE USE ONLY**-----
MEDICAL HISTORY UPDATED

DR. Date DR. Date DR. Date