Medical History Form

Date ______________________

Patient Information

Patient's Name: ____
LAST FIRST MIDDLE INITIAL

Social Security Number ______________________ Sex: M F Date of Birth ________________ Age ____

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

Responsible Party Information

Last Name ______________ First ______________ Middle ____________ Marital Status __

Address ______________________ City ____________ State ________ Zip ________

Driver's License No. ______________ Home Phone ______________ Work Phone ______________

Date of Birth ______________ Relationship to Patient ______________________

Employer ______________ Occupation ______________ No. of Years Employed ________

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

Email ____

How did you hear about us? Please check below:

- ☐ Yellow Pages
- ☐ Friend / Relative
- ☐ Radio Ad. - Which Station? ____________
- ☐ Bill Board
- ☐ Sign
- ☐ Mail Coupon
- ☐ TV Ad. - Which Station? ____________
- ☐ Employer
- ☐ Employee
- ☐ Health Fairs / Screenings
- ☐ News Paper - Which one? ____________
- ☐ Other (Specify) ____________

Reason for today's dental visit ____

Date of last dental visit ______________________ Reason ______________________

Have you ever had an experience in a dental office, that you would like to tell us about? YES NO If YES, please explain ____________

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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 unhappy with the appearance of your teeth?	YES	NO

If so, what is the condition being treated? ____

The Name & Address of my Physician (s) is ____

What medications are you taking now? ____

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

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

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

Mark any of the following medications you are allergic to:

- ☐ Local Anesthetics
- ☐ Penicillin or other antibiotic
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Iodine
- ☐ Other ____

MEDICAL HISTORY UPDATED:

______________________ ______________________ ______________________
DR. DATE DR. DATE DR.

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 ch
I will inform my dentist at the next appointment.

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Signature of Patient / Parent / Guardian