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 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**

☐ 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