TODAY'S DATE: ____________________________

MEDICAL HISTORY FORM

Patient's Name: ____
Last First Middle

Social Security Number: ______________________ Sex: M F Date of Birth: ____________________ Age: ________

If Patient is a Minor, please provide Parent's or Guardian's Name: ____

RESPONSIBLE PARTY INFORMATION

Name: ____ Marital Status: ______________
Last First Middle

Address: ______________________________________ City: ____________________ State: ________ Zip: __________

Driver's License #: ____________________ Date of Birth: ____________________ Relationship to Patient: ________________

Telephone #'s: Home (______)________________ Cell (______)____________________ Work (______)____________________

Email Address: ____

Employer: ______________________________________ Occupation: ______________________________

Name/Address/Phone of nearest relative not living with you: ____

How did you hear about us? Please check below:

- ☐ Yellow Pages
- ☐ Television
- ☐ Radio Ad
- ☐ Billboard
- ☐ Health Fair/Screenings
- ☐ Friend/Relative
- ☐ Newspaper
- ☐ Mail Coupon
- ☐ Employer
- ☐ Sign
- ☐ Employee
- ☐ Other: ____

Reason for today's visit: ____

Date of last dental visit: ____________________________ Reason: ______________________________________

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

____

Are you apprehensive about dental treatment? YES NO

Do your gums bleed, feel tender or irritated? YES NO

Are you now seeing a physician? YES NO

Are your teeth sensitive to hot/cold/sweets/pressure? YES NO

Do you have discolored teeth that bother you? YES NO

Are you happy with the appearance of your teeth? YES NO

If so, what is the condition being treated? ____

Name/Address/Phone Number of Physician: ____

What medications are you taking now? ____

If female, are you pregnant? YES NO If yes, how far along? ______________________________________

MARK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

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

MARK ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

- ☐ Local Anesthetics
- ☐ Aspirin
- ☐ Iodine
- ☐ Penicillin or Other Antibiotic
- ☐ Codeine or Other Narcotics
- ☐ Other ______________________________________
- ☐ Sulfa Drugs
- ☐ Barbiturates Sedative or Sleeping Pills

To the best of my knowledge all the preceeding answers are true and correct. If I ever have any changes in my health or if any medicines change, I will inform my dentist at the next appointment.

X ______________________________________ ______________________
Patient/Parent/Guardian Signature Date

______________________________________ ______________________
Doctor's Signature Date

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