ABC DENTAL
Family Dentistry

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

MARK ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

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

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