(Please Print)

PATIENT MEDICAL HISTORY

Patient Complete Only This Side

Name _____ Age _____ Birth Date _____ Sex F M

Address _____ City _____ Zip Code _____ County _____

Phone (Area Code) (___) _____ Work Phone (Area Code) (___) _____ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Employer _____ Social Security No. _____

Spouse's Name _____ or (If Dependent) Parent's Name _____

Whom may we thank for this referral? _____

Physician _____ Office Phone _____

Approximate Date of Last Physical _____ Results _____

If your answer to any of the following is "yes" please explain at the bottom.

Are you under any medical treatment? ..... Yes No
Are you taking any medication, pills, or drugs? ..... Yes No
Are you allergic to any medication, local anesthetic or material resulting in hives, asthma, etc? ..... Yes No
Have you had any major operations? ..... Yes No
Have any wounds healed slowly or presented complications after extraction such as prolonged bleeding? ..... Yes No
Do you have a history of fainting? ..... Yes No
Have you ever had a serious accident involving head injuries? ..... Yes No
Have you had any x-ray treatments (Other than diagnostic) to head or neck? ..... Yes No
Do you have any artificial joints (knee, hip, etc)? ..... Yes No
Are you in the high risk group for AIDS ..... Yes No

DO YOU HAVE OR HAVE YOU EVER HAD?

Heart Condition	Yes No	Diabetes	Yes No
High/low Blood Pressure	Yes No	Cortisone-steroid Treatment	Yes No
Do you have a pacemaker?	Yes No	Respiratory Disease	Yes No
Heart Murmur	Yes No	Sinus Problems	Yes No
Rheumatic Fever	Yes No	Tuberculosis	Yes No
Anemia	Yes No	Asthma-Hay Fever	Yes No
Blood Transfusions	Yes No	Kidney Trouble	Yes No
Blood Disease	Yes No	Arthritis	Yes No
Liver Disease	Yes No	Tumor or Malignancy	Yes No
Hepatitis-Jaundice	Yes No	Venereal Disease	Yes No
Nervous Disorder	Yes No	Are you Pregnant?	Yes No
Epilepsy	Yes No	If yes, delivery date _____	

Dental Information

Date of last dental visit _____ Were x-rays taken at that time? ..... Yes No

Do you have an immediate dental problem? ..... Yes No

If so, where does it bother you? _____

When did it start? _____

What type of discomfort: Throbbing ___ Constant ___ Dull ache ___ Hot & Cold___

Were your teeth cleaned at that time? ..... Yes No

Are you interested in emergency treatment or should we arrange a complete exam?

_____

Insurance Information (Dental)

Employer: _____

Carrier Name: _____

Address: _____

_____

Group # _____

Policy # _____

Subscriber Name: _____

Secondary Insurance: _____

_____

_____

_____

I acknowledge that the above information is correct to the best of my knowledge.

Signature: _____ *Date*: _____

Medical Information

List Medications

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies _____ _____

_____ _____

Comments:

_____

_____

_____

For The Office: _____ *Date:* _____