MEDICAL HISTORY FORM

Patient Information

Date: _____

Patient's Name: _____
Last First Middle Initial

Address: _____
Address City State Zip Code

Email Address: _____ **SSN:** _____ **Date of Birth:** _____ **Age:** _____

☐ M ☐ F **Home No:** _____ **Cell No:** _____ **Alt. No:** _____

Parent/Guardian Insurance Information

Name: _____
Last First Middle Initial

Relationship to Patient: _____ ☐ SELF

Subscriber / Member ID: _____ **Group No.:** _____

Date of Birth: _____ **Insurance Telephone No.:** _____ **Group No.:** _____

Employer: _____ **Address:** _____

Home No: _____ **Cell No:** _____

Emergency Contact: _____

How did you hear about us?

☐ Online ☐ Dr. Referral ☐ Friend / Relative

☐ Driving / Walking by the Office ☐ Employee ☐ Insurance / Employer

☐ Community Event ☐ Other (Specify)

Reason for today's visit: _____ **Date of last dental visit:** _____

Dental and Medical Questions

Are you nervous about dental treatment?	☐ Yes	☐ No
Are you unhappy with appearance of your teeth?	☐ Yes	☐ No
Are your teeth sensitive?	☐ Yes	☐ No
Are you now seeing a physician?	☐ Yes	☐ No
Are you taking any medications?	☐ Yes	☐ No
Have you or are you currently taking Aspirin?	☐ Yes	☐ No
Do you use tobacco?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
If female, are you or do you suspect to be pregnant?	☐ Yes	☐ No
Have you had any joint replacements?	☐ Yes	☐ No
Do you take prescribed medication for dental visits?	☐ Yes	☐ No
Do you grind your teeth?	☐ Yes	☐ No
Do you have pain in your teeth?	☐ Yes	☐ No

Do your gums bleed, feel tender or irritated? Yes No

If yes, to what? Sweets Hot Cold Pressure

Please list medications:

_____

_____

_____

_____

_____

_____

_____

Where is the pain? _____

Is there anything else we should know about your health that was not covered on this form? Yes ☐ No ☐

If yes, please explain: _____

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Medical Conditions

☐ NONE

☐ Heart Disease	☐ Heart Murmur	☐ High Blood Pressure	☐ Blood Disease	☐ Rheumatic Fever
☐ Venereal Disease	☐ Heart Pacemaker	☐ Anemia	☐ Kidney Trouble	☐ Bone Loss
☐ Epilepsy or Seizures	☐ Ulcers	☐ Emphysema	☐ Tuberculosis	☐ Nervousness
☐ Thyroid Disease	☐ Chemo: cancer, leukemia	☐ Arthritis	☐ Rheumatism	☐ Cortisone Medicine
☐ Joint Replacement	☐ HIV + AIDS	☐ Hepatitis	☐ Hemophilia	☐ Sickle Cell Disease
☐ Bruise Easily	☐ Pain in Jaw Joint	☐ Diabetes	☐ Asthma	☐ Scarlet Fever
☐ Hay Fever	☐ Glaucoma	☐ Dementia / Alzheimer's	☐ Autism	☐ Other

Special needs (ADHD, Down Syndrome, Mental Health Conditions, Etc.): _____

Other condition(s): _____

Medical Allergies

☐ NONE

☐ Local Anesthetics	☐ Aspirin	☐ Iodine
☐ Penicillin	☐ Other antibiotic	☐ Sulfa Drugs
☐ Codeine or other narcotics	☐ Barbiturates or sedatives	☐ Latex
☐ Fen-Phen	☐ Bleach	☐ Hydrogen Peroxide
☐ Other		

Other allergies: _____

Acknowledgment and Signature

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 change, I will inform my dentist at the next appointment.

Signature of Patient / Parent / Guardian: _____

Date: _____