MEDICAL HISTORY

Name _____ Date _____
Last First Middle

Home Address _____
Number, Street, State & Zip

Mailing Address *(if different from home)* _____ Email Address: _____
Number, Street, State & Zip

Home Phone _____ Cell Phone _____ Business Phone _____

Date of Birth _____ Sex _____ Height _____ Weight _____ Occupation _____

Social Security No. _____ Single _____ Married _____ Name of Spouse _____

Closest Relative _____ Phone _____

If you are completing this form for another person, what is your relationship to that person? _____

Whom may we thank for referring you? _____

Name of General Dentist: _____
Name City State

In the following questions circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. The name and address of my physician is: _____
Name City State
2. My last physical examination was on: _____
3. Are you now under the care of a physician? ..... Yes No
   a. If yes, what is the condition being treated? _____
4. Have you had any serious illness or operation? ..... Yes No
   a. If so, what was the illness or operation? _____
5. Do you have or have you had any of the following diseases or problems?
   a. Artificial heart valves, rheumatic fever, damaged heart valves or heart murmur ..... Yes No
   b. Cardiovascular disease (heart trouble, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, angina) ..... Yes No
      1) Do you have a cardiac pacemaker? ..... Yes No
      2) Do you have chest pain upon exertion? ..... Yes No
      3) Do you get short of breath when you lie down, exercise, or do you require extra pillows when you sleep? .... Yes No
   c. Asthma or hay fever ..... Yes No
   d. Fainting spells or seizures ..... Yes No
   e. Diabetes ..... Yes No
      1) Does your mouth frequently become dry? ..... Yes No
   f. Hepatitis, jaundice or liver disease ..... Yes No
   g. Have you ever been told you have AIDS, ARC or any immune deficiencies ..... Yes No
   h. Arthritis or inflammatory rheumatism ..... Yes No
   i. Stomach ulcers ..... Yes No
   j. Kidney trouble ..... Yes No
   k. Tuberculosis ..... Yes No
   l. Do you have a persistent cough or cough up blood ..... Yes No
   m. Venereal disease ..... Yes No
   n. Allergies to (ie. latex, environmental, medications, or others) ..... Yes No
      Please list _____
   o. Other _____
6. Have you had abnormal bleeding associated with previous dental extractions, surgery, or trauma ..... Yes No
7. Do you have any blood disorder such as anemia ..... Yes No
8. Have you had surgery or X-RAY TREATMENT for a tumor, growth, or other condition of the head or neck ..... Yes No

9. Are you taking **any** drug or medicine prescribed or non-prescribed, including herbal remedies or over the counter medications ..... Yes No

If so, what _____

10. Are you allergic or have you reacted adversely to ANY medication: ..... Yes No

If so, what _____

11. Do you have any disease, condition or problem not listed above that you think I should know about? ..... Yes No

If so, explain _____

_____

12. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... Yes No

13. Smoking History:

a. Do you smoke? ..... Yes No

b. Have you ever smoked? ..... Yes No

c. How much do you or did you smoke? _____

d. How long have you smoked? _____

WOMEN

14. Are you pregnant? ..... Yes No

15. Do you have problems associated with your menstrual period? ..... Yes No

16. Are you nursing? ..... Yes No

17. Dental History:

a. Have you had any previous periodontal care? ..... Yes No

b. Did you ever have orthodontic care? ..... Yes No

c. Do you have regular routine dental care? ..... Yes No

1) How often do you have your teeth cleaned? _____

2) Has there ever been a significant lapse in your dental care? ..... Yes No

If so, for how long? _____

d. Do you have any anxiety regarding dental treatment? ..... Yes No

CHIEF DENTAL COMPLAINT: _____

_____

_____

Responsible Party _____
Name (if other than yourself)

_____
Address (if different from above)

Your employer _____
Name

_____
Address

Do you have **DENTAL** insurance? Yes___ No___

Name of Insurance company _____ Policy # _____

I hereby consent to the release of any pertinent information to other healthcare providers involved in my care.

_____
Signature of patient/guardian

I hereby consent to the release of information required for preauthorization and or payment by third parties for my treatment. I understand that I am responsible for any amount not covered by the third party.

_____
Signature of patient/guardian