Medical History

Name _____ Address _____

City _____ State _____ Zip Code _____Home Phone_____ Cell #_____

Date of Birth _____ Sex ____ Employer _____Work #_____ E-mail_____

Social Security # _____ Single/Married Name of Spouse _____

Closest Relative _____ Phone _____

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

Referred By _____

Insurance Information

Name of insured _____Relationship to Patient_____

Birth date _____ Social Security # _____Date employed _____

Name of Employer _____ Union or local # _____ Work Phone _____

Insurance Company_____ Group # _____ Policy/ID # _____

Ins. Co. Address _____City _____State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? IF YES, COMPLETE THE FOLLOWING.

Name of insured _____ Relationship to Patient _____

Birth date _____ Social Security # _____ Date employed _____

Name of Employer _____ Union or local # _____Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

Do you have any of the following?

High Blood Pressure	Yes No	Anemia	Yes No
Heart Attack	Yes No	Emphysema	Yes No
Rheumatic Fever	Yes No	Cancer	Yes No
Swollen Ankles	Yes No	Arthritis	Yes No
Fainting/Seizures	Yes No	Joint Replacement	Yes No
Asthma	Yes No	Implants	Yes No
Low Blood Pressure	Yes No	Hepatitis/Jaundice	Yes No
Epilepsy/Convulsions	Yes No	Sexually Transmitted	
Leukemia	Yes No	Diseases.....	Yes No
Kidney Disease	Yes No	Stomach Troubles/Ulcers	Yes No
Diabetes	Yes No	Chest Pains	Yes No
AIDS or HIV Infection	Yes No	Easily Winded	Yes No
Thyroid Problem	Yes No	Stroke	Yes No
Heart Disease	Yes No	Hay Fever/Allergies	Yes No
Cardiac Pacemaker	Yes No	Tuberculosis	Yes No
Angina	Yes No	Radiation Therapy	Yes No
Frequently Tired	Yes No	Mitral Valve Prolapse	Yes No
High Cholesterol	Yes No	Other Medical Problems	Yes No

_____

Are you taking any of the following?

a. Antibiotics or sulfa drugs..... Yes No
b. Anticoagulants (blood thinners)..... Yes No
c. Medicine for high blood pressure..... Yes No
d. Cortisone (steroids)..... Yes No
e. Tranquilizers..... Yes No
f. Antihistamines..... Yes No
g. Aspirin..... Yes No
h. Insulin, tolbutamide (Orinas) or similar drug..... Yes No
i. Digitalis or drugs for heart problems..... Yes No
j. Nitroglycerin..... Yes No
k. Oral contraceptives or other hormonal therapy..... Yes No
l. High Cholesterol Meds..... Yes No
m. Other Medications_____

Are you allergic or have you reacted adversely to:

a. Local anesthetics..... Yes No
b. Penicillin or other antibiotics..... Yes No
c. Sulfa drugs..... Yes No
d. Barbiturates, sedatives, or sleeping pills..... Yes No
e. Aspirin..... Yes No
f. Iodine..... Yes No
g. Codeine or other narcotics..... Yes No
h. Latex..... Yes No
Other Drug Allergies _____

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

Have you had any problems associated with any dental treatment? Yes No
If so, explain_____.

Are you happy with the color/shade of your teeth? Yes No

Chief dental complaint_____

Are you wearing removable dental appliances? Yes No

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

Are you currently or have you ever smoked? Yes No
History of:_____

Women:
Are you pregnant? Yes No
Do you have any problems associated with your menstrual period? Yes No
Are you nursing? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient signature Date

Doctor signature Date