MEDICAL / DENTAL HISTORY FORM

Today's Date _____

Patient Name: _____ Date of Birth _____

Address: _____ Spouse/Parent's Name: _____

_____ Social Security Number: _____

Home Phone Number: _____ Physician's Name: _____

Cell Phone Number: _____ Physician's Office Name: _____

Work Phone Number: _____ Physician's Phone Number: _____

Physician's Location: _____

Pharmacy Name & Phone Number:

MEDICAL HISTORY

Please circle any of the following which you have had or have at present:

Heart Failure	Swollen Ankles	Ulcers
Heart Disease/Attack	Mental Retardation	HIV Positive, ARC, AIDS
Heart Palpitations from Novocaine	Emphysema	Hepatitis A(infectious)
Angina Pectoris	Cough	Hepatitis B (serum)
High Blood Pressure	Tuberculosis (TB)	Hepatitis C
Low Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Mitral Valve Prolapse	Allergies or Hives	Drug Addiction
Atrial Fibrillation	Kidney Trouble	Glaucoma
Congenital Heart Lesions	Diabetes	Hemophilia
Use of tobacco products	Sexually Transmitted Diseases	Any type of transplant
Thyroid Disease	Radiation Therapy	Herpes
Heart Pacemaker	Sickle Cell Anemia	Epilepsy/Seizures
Heart Surgery	Arthritis	Fainting/Dizzy Spells
Cancer (Type _____)	Alcoholism	Any type of implant(Heart valve)
Chemotherapy	Rheumatism	Psychiatric treatment
Anemia	Cortisone Medicine	Renal Dialysis
Stroke	Artificial hip, knee, etc.	Bruise easily
Lupus	Birth Defects	

NOTES:

Have you been a patient in the hospital during the past two years. Y N

Have you been under the care of a medical doctor during the past 2 years Y N

Have you taken any medicines or drugs in the last 2 years Y N

Are you allergic to (I.e. itching, rash, swelling of hands, feet or eyes)?

Penicillin	…. Y N	Barbiturates…	Y N		
Latex	…. Y N	Aspirin……..	Y N		
Metals	…. Y N	Codeine…….	Y N		
Iodine	…. Y N	Local Anesthetic (Novocaine)	Y N		
Other	…. Y N				

Have you ever had any excessive bleeding requiring special treatment?…. Y N

Are you taking or have you taken *FenPhen or *Viagra?…… Y N

Are you taking Fosamax?..... Y N

* These medications can affect your heart adversely

WOMEN ONLY: Are you pregnant or think you may be pregnant?…… Y N

Are you nursing?…… Y N

Are you taking birth control pills? …… Y N

Medications: 1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

YOUR INITIALS

Complete for subsequent visits only: I have reviewed my health history and have noted any changes.

_____ Initial/Date	_____ Initial/Date	_____ Initial/Date
_____ Initial/Date	_____ Initial/Date	_____ Initial/Date
_____ Initial/Date	_____ Initial/Date	_____ Initial/Date

DENTAL HISTORY

Date of last dental examination _____ Previous Dentist's Name _____

Date of last dental x-rays: _____

Are you having pain or discomfort at this time?……..	Y	N
Do you feel very nervous about having dental treatment?……..	Y	N
Have you ever had a bad experience in the dental office?……	Y	N
Is there anything that you dislike about your smile?……..	Y	N
Have you ever had any instructions in oral hygiene?……	Y	N
Are there now any growths or sores in or around your mouth?……	Y	N
Do you have any trouble chewing?…….	Y	N
Does food catch between your teeth?…….	Y	N
Do you have pain in or near your ears?…….	Y	N
Do you habitually clench or grind your teeth during the day or night?…..	Y	N
Have you ever been told that you have gum problems?……	Y	N
Do you now have bleeding gums or any other gum conditions?…….	Y	N

Is there anything related to your medical or dental history that you have not indicated above?

If yes, please explain _____

Purpose of this dental visit _____

Comments: _____

MORE INFORMATION ABOUT YOU

Email Address _____ Marital Status ____S____M____D____W

Full Time Student? _____Y_____N Name of School _____

Insurance Information

Name of Insured Party _____ ID#_____

Address _____ SS#_____

_____ Birthdate_____

Insurance Plan Name _____ Insurance Ph. #_____

Address _____ Group # _____

_____

Employer Name _____

Responsible Party Information

Name _____

Address _____

_____

Phone Number _____

SS# _____

Birthdate _____

I acknowledge that payment is expected the date services are rendered. (Those with insurance are responsible for the balance of what their insurance does not pay). _____

AUTHORIZATION & CONSENT

I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to treatment.

I understand that my health history information will be used as necessary for diagnosis or treatment by the doctors.

I hereby authorize and request the performance of dental services for :

1) Myself _____

or

2) Patient Name _____ Age: _____

Guardian Signature _____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes or dental treatment.

Signature of Responsible Party: _____

Relationship to other(s) named: _____ Date_____

Updated 1/17/08

Found: General Office Server/Front Desk/Front Desk Forms/Medical History Form