

# Medical History Form

Date \_\_\_\_\_

## Patient Information:

Patient's Name \_\_\_\_\_  
Last First Middle  
Social Security Number \_\_\_\_\_ Sex M F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

If Patient is a Minor, give Parent or Guardian's Name \_\_\_\_\_

## Responsible Party Information:

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Email: \_\_\_\_\_

Name/Address/Phone No. of nearest relative not living with you: \_\_\_\_\_

Reason for today's dental visit \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Reason \_\_\_\_\_

Have you ever had an experience in a dental office which you would like to tell us about? YES / NO. If yes, please explain:

Are you apprehensive about dental treatment? YES NO Are your teeth sensitive to hot, cold, sweets, pressure? YES NO

Do your gums bleed, feel tender or irritated? YES NO Do you have discolored teeth that bother you? YES NO

Are you seeing a physician? YES NO Are you happy with the appearance of your teeth? YES NO

If so, what is the condition being treated?

The Name & Address of your physician(s): \_\_\_\_\_

What medication are you taking now? \_\_\_\_\_

If female, are you pregnant? YES NO. If yes, how long? \_\_\_\_\_

How did you hear about us? Please circle below:

Telephone Book – Which one \_\_\_\_\_ Employee \_\_\_\_\_ Employer \_\_\_\_\_ Sign/Flyer  
Friend/Relative Health Fair/Screening Other (Specify) \_\_\_\_\_

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

ADD/ADHD	Diabetes	Heart Disease	Kidney Problems
Asthma	Anemia	Heart Murmur	Chemo (Cancer, Leukemia)
Autism	Bruise Easily	High Blood Pressure	Glaucoma
Hepatitis	Epilepsy or Seizure	Scarlet Fever	Rheumatism
HIV	Thyroid Disease	Emphysema	Tuberculosis
Heart Pacemaker	Osteoporosis	Other _____	

Circle any of the following you are allergic to:

Aspirin/Ibuprofen/Tylenol	Barbiturates, sedatives, or sleeping pills	Codeine or other narcotics	Local Anesthetic/Lidocaine
Latex	Penicillin or other antibiotics	Sulfa Drugs	Other _____

I have answer all the above to the best of my knowledge. If I have any changes to my health or any changes to my medication, I will inform my dentist during my next appointment.

\_\_\_\_\_  
Signature of Patient / Parent / Guardian

-----**FOR OFFICE USE ONLY**-----  
MEDICAL HISTORY UPDATED

_____ DR.	_____ Date	_____ DR.	_____ Date	_____ DR.	_____ Date
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