PATIENT MEDICAL HISTORY

Patient's Name: | Preferred Name:

Address: | Today's Date:

City State Zip | Home Phone: | Cell Phone:

Email Address: | Birthdate: | S.S. Number: | Marital Status: | Sex:

Person Responsible For Bill: | Employer:

Business Address: | City State Zip

Spouse's Name: | Birthdate: | Employer: | S.S. Number:

Dental Insurance Co. | Group Number: | I.D. Number:

Physician's Name: | Phone Number: | Referred By:

Do you have any dental complaints? Y N ______________________________

Are you happy with the appearance of your teeth? Y N______________________________

If you could, how would you change the appearance of your teeth?______________________________

Do you smoke or use tobacco? Y N______________________________

If female, please answer the following:

Y	N	
☐	☐	Are you taking birth control pills?
☐	☐	Are you pregnant? If yes, # of weeks______
☐	☐	Are you nursing?
☐	☐	Are you taking medication for osteoporosis? Medication____________________

Allergies:

Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Aspirin
☐	☐	Novocaine	☐	☐	Latex
☐	☐	Tetracycline	☐	☐	Metals
☐	☐	Codeine	☐	☐	Other ________

Y	N	CONDITIONS:	Y	N	CONDITIONS:	Y	N	CONDITIONS:
☐	☐	Abnormal Bleeding	☐	☐	Diabetes	☐	☐	High Blood Pressure
☐	☐	Alcohol Abuse	☐	☐	Drug Abuse	☐	☐	Joint Replacement
☐	☐	Allergies	☐	☐	Emphysema	☐	☐	Liver Disease
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Mitral Valve Prolapse
☐	☐	Angina Pectoris	☐	☐	Fainting Spells	☐	☐	Pace Maker
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Radiation Therapy
☐	☐	Artificial Heart Valve	☐	☐	HIV+ AIDS	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Heart Ailment	☐	☐	Seizures
☐	☐	Cancer	☐	☐	Heart Attack	☐	☐	Stroke
☐	☐	Colitis	☐	☐	Heart Surgery	☐	☐	Thyroid Problems
☐	☐	Congenital Heart Defect	☐	☐	Hepatitis	☐	☐	TB

MEDICATIONS:

Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below.

Y ☐ N ☐

Signature: ______________________________________ Date: _________________________

(If under 18, parent or guardian signature required)