Dental/Medical History Form

Name: _____ Date:_____

Sex: Male / Female Height: _____ Weight: _____ DOB _____/_____/_____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

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

Insurance Company: _____ Insurance Company Address: _____

Subscriber I.D. # _____ Group # _____

Person Responsible for account: _____ Relationship to Patient: _____

Responsible Party Employed By: _____ Business Phone: _____

Business Address: _____ Occupation: _____

1. What is your primary dental complaint? _____

2. When was your last dental cleaning? _____ Your last complete dental exam? _____

Your last Full mouth X-Ray? _____

3. Do you have an uncompleted treatment from your last dental visit? _____

4. Are you satisfied with your smile? Yes/No If No, Why? _____

_____

5. Have you ever been told you have, or have symptoms of gum disease (bleeding gums, sore gums, bad taste or odor in the mouth, loose teeth)? Yes/No

6. Do you suffer from frequent migraine headaches or have problems with your Jaw Joint? Yes No

For the following questions please circle all answers that apply, if none apply please check none.

Do you have, or have you ever had any of the following: Circle all that apply.

Heart Murmur	Rheumatic Fever	Vascular Shunt	High Blood Pressure	Coronary Occlusion
Arteriosclerosis	Stroke	Heart Attack	Chest Pain	Artificial lHeart Valves
Heart Defect	Pacemaker	Heart Surgery	Congestive Heart Failure	
AIDS/HIV	Hepatitis	Tuberculosis	Sexually Transmitted Disease	**NONE**

Are you allergic to any of the following: Circle all that apply

Penicillin	Sulfa	Erythromycin	Local Anesthetics	Other Medicine
Codeine	Nickel/Other Metals	Latex		No Allergies

Do you have, or have you had, any problems with the following: Circle all that apply.

Sinus Trouble	Asthma	Bronchitis	Emphysema	Other Respiratory Problems
Diabetes	Thyroid Disorder	Liver Problems	Kidney or Adrenal Problems	Swelling of feet/ankles
Neurological Problems	Colitis	Stomach Ulcer	Hiatal Hernia	Jaundice
Neurological Problems	Fainting	Seizures	Epilepsy	Mental Health Problems
Depression	Abnormal Bleeding	Clotting Problems	Phlebitis	Anemia Transfusions
Cancer	Tumor(s)	Cyst	Biopsy	
Arthritis	Artificial Joints	Muscle or Bone Disease		NONE
Are you Pregnant?	Taking Birth Control?	Nursing?		

Do You: Circle all that apply.

Smoke	Drink Alcohol	Use Illegal Drugs	Use Chewing Tobacco/Snuff			