

# MEDICAL HISTORY

- |  |     |    |
|--|-----|----|
| 1. Are you having pain or discomfort at this time? .....                             | YES | NO |
| 2. Do you feel very nervous about having dentistry treatment? .....                  | YES | NO |
| 3. Have you ever had a bad experience in a dental office? .....                      | YES | NO |
| 4. Have you been a patient in the hospital during the past two years? .....          | YES | NO |
| 5. Have you been under the care of a medical doctor during the past two years? ..... | YES | NO |

Physician's Name \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # \_\_\_\_\_

- |  |     |    |
|--|-----|----|
| 6. Have you taken any medicine or drugs during the past two years? ..... | YES | NO |
| Are you now taking any medication, drugs, pills or daily aspirin? .....  | YES | NO |
| If yes, please list those drugs _____                                    |     |    |

- |  |     |    |
|--|-----|----|
| 7. Are you aware of being allergic to any other medication or substance? ..... | YES | NO |
| If yes, please list: _____   |     |    |

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

- |  |                           |                          |                              |
|--|---------------------------|--------------------------|------------------------------|
| Allergies or Hives                       | Cleft Palate              | Heart Murmur             | Rheumatic Fever              |
| Alzheimer's                              | Cold Sores/Fever Blisters | Heart Pacemaker          | Rheumatism                   |
| Anemia                                   | Congenital Heart Lesions  | Heart Surgery/Trouble    | Scarlet Fever                |
| Anesthetic Allergy                       | Cortisone Treatments      | Hepatitis, A, B or C     | Sexually Transmitted Disease |
| Angina Pectoris                          | Cystic Fibrosis           | High/Low Blood Pressure  | Shunt                        |
| Arthritis                                | Diabetic                  | HIV/AIDS                 | Sickle Cell Disease          |
| Artificial Heart Valve                   | Drug Addiction            | Jaundice                 | Spleen Removed               |
| Artificial Joint (Hip, Knee) or Implants | Emphysema                 | Kidney Trouble           | Stroke                       |
| Asthma                                   | Epilepsy/Seizures         | Latex Allergy            | Thyroid Disease              |
| Bleeding Disorders                       | Fainting/Dizziness        | Leukemia                 | TMD/TMJ-Pain in jaw joints   |
| Blood Thinner                            | Fosamax/Actonel           | Liver Disease            | Tuberculosis (TB)            |
| Blood Transfusion                        | Gag Reflex                | Mental Disorders/Illness | Tumor or Growth              |
| Bronchitis/Chronic Cough                 | Glaucoma                  | Mitral Valve Prolapse    | Xray or Cobalt Treatment     |
| Bruise Easily                            | Hay Fever/Sinus Trouble   | Nervousness              |                              |
| Cancer/Chemotherapy/Radiation            | Heart Disease or Attack   | Osteoporosis             |                              |
|  | Heart Failure             | Psychiatric Treatment    |                              |

- |   |     |    |
|---|-----|----|
| 9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... | YES | NO |
| 10. Do your ankles swell during the day? .....  | YES | NO |
| 11. Do you use more than 2 pillows to sleep? .....  | YES | NO |
| 12. Have you lost or gained more than 10 pounds in the past years? .....  | YES | NO |
| 13. Do you ever wake up from sleep short of breath? .....   | YES | NO |
| 14. Are you on a special diet? .....  | YES | NO |
| 15. Do you smoke cigarettes? .....  | YES | NO |
| Packs per day _____   |     |    |
| 16. Do you have any disease, condition, or problem not listed? .....  | YES | NO |

**FOR WOMEN ONLY:**

Are you pregnant? Yes No If yes, what month? \_\_\_\_\_ Are you taking birth control pills? Yes No  
*(Occasionally antibiotics interfere with the effectiveness of birth control pills.)*

**CONSENT:**

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connections with (Name of Patient) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient or Parent _____	Date _____	Witness _____
Patient or Parent _____	Date _____	Patient or Parent _____
Patient or Parent _____	Date _____	Patient or Parent _____
Patient or Parent _____	Date _____	Patient or Parent _____
Patient or Parent _____	Date _____	Patient or Parent _____
Patient or Parent _____	Date _____	Patient or Parent _____

**Please complete the following  
confidential information**

IF THIS  
APPOINTMENT  
IS FOR YOU  
START HERE

IF THIS  
APPOINTMENT  
IS FOR  
YOUR CHILD  
START HERE

Date _____	<b>1</b>
Name _____ Sex M F	
Spouse _____	
Address _____	
City _____ State _____ Zip _____	
Home Phone # _____	
Cell Phone # _____	
E-mail Address _____	
Birthdate _____ Age _____	
Married _____ Single _____ Divorced _____ Widowed _____	
Your SS# _____	
Date _____	
Name _____	
Address _____	
Home Phone # _____	
Birthdate _____ Age _____ Sex M F	
Child's SS# _____	

<b>DENTAL INSURANCE</b>	<b>2</b>
<b>Primary Insurance</b>	
Insurance Co. _____	
Phone # _____	
Group # _____	
Policy Holder's Name _____	
Policy Holder's Birthdate _____	
Social Security # _____	
Policy ID # _____	
Coverage Single or Family (Circle One)	
<b>Secondary/Additional Insurance</b>	
Insurance Co. _____	
Phone # _____	
Group# _____	
Policy Holder's Name _____	
Policy Holder's Birthdate _____	
Social Security # _____	
Policy # _____	
Coverage Single or Family (Circle One)	

<b>ACCOUNT INFORMATION</b>	<b>4</b>
Person responsible for account _____	
Bank _____	
Your Employer _____	
Business Address _____ City _____	
Business Telephone _____ Ext. _____	
<b>YOUR SPOUSE</b>	
Name _____	
Occupation _____	
Employer _____	
Business Address _____ City _____	
Business Telephone _____ Ext. _____	

<b>GETTING TO KNOW YOU</b>	<b>3</b>
Is another member of your family, or relative a patient at our office? _____	
Who may we thank for referring you to our office? _____	
Person to contact for emergency _____ Phone _____	
Closest relative not living with you _____ Phone _____	
Address _____ _____	
Previous Dentist _____ Phone # _____	