

Name _____ Date _____
Address _____
City _____ State _____ Zip _____ Home Phone _____
Social Security # _____ Business Phone _____
Date of Birth _____ Cell Phone _____
Employer _____ Email _____
Employer's Address _____
Who may we thank for referring you to our office? _____

MEDICAL HISTORY

Physician _____ Address _____ Phone _____
Are you under the care of a Physician? _____ If so, for what reason? _____
Are you taking ANY medications (prescription or over the counter)? Yes No
If yes, please list. _____
Are you ALLERGIC to any medications, foods, metals, latex, or plastics, etc.? Yes No
If yes, please list. _____
Please CIRCLE the following, if you have now or a history of:
AIDS, ARC, or HIV Chemotherapy Hepatitis Sinus Trouble
Alcoholism Congenital Heart Disease* Herpes Stomach/Acid Reflux
Alzheimer's Disease Diabetes High Blood Pressure Stroke
Anemia Emphysema Hives Rash Tuberculosis
Angina Proctosis Epilepsy or Seizures Liver Disease
Arthritis/Gout Fainting or Dizzy Spells Mitral Valve Prolapse*
Artificial Heart Valve* Glaucoma Organ Transplant*
Artificial Joint (Hip, Knee Etc.)* Heart Attack/Failure Psychiatric Care
Asthma Heart Murmur* Radiation Treatments
Blood Transfusion Heart Pace Maker* Rheumatic Fever
Bruise Easily Heart Trouble/Disease Shingles
Cancer /HPV(Type _____) Hemophilia Sickle Cell Disease

Women Only: Are You: Pregnant, Trying to get pregnant, Nursing or Taking Oral Contraceptives
**Antibiotic premedication may be required prior to your appointment.*

DENTAL HISTORY

Purpose for this visit _____
Previous Dentist _____ Address _____ Phone _____
Date of last cleaning _____ last x-rays taken _____

Do you have trouble chewing? Yes No
Do you have constant bad breath? Yes No
Do your gums bleed? Yes No
Do you clench or grind your teeth? Yes No
Do you have pain in or near your ears? Yes No
Are you on a special diet? Yes No

What about your smile would you like to change? _____
Are there any interests or concerns that you would like addressed at this visit? _____
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**\*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

**Signature of Patient or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_  
*\*Signature authorized above statement.*