

PATIENT'S HEALTH AND DENTAL HISTORY

In order to help me render the proper dental services to you, please be kind enough to answer the following questions. Please note the spaces for remarks that require clarification or any other information you think I should know. Thank you for your cooperation.

Today's Date _____
Patient's Name _____
Home Address _____

E-mail _____
Phone _____ SS# _____
Date of Birth _____ Sex: M F

By what name would you prefer to be called? _____
Employer Name _____
Address _____
Business Phone _____
Patient's Occupation _____
Cell _____
Preferred method of contact _____

Marital Status (circle) S M W D If married, spouse's name _____
Dental Insurance Carrier _____ ID# _____
Secondary Insurance _____ ID# _____
Who may we thank for referring you? _____

*****Wife or Mother (circle one)*****

*****Husband or Father (circle one)*****

Name _____
Address _____
Phone _____ Work _____
Employer _____
SS# _____ D.O.B. _____

Name _____
Address _____
Phone _____ Work _____
Employer _____
SS# _____ D.O.B. _____

MEDICAL HEALTH

General Health Excellent Good Fair Poor

Name and address of physician _____

Date of last complete physical _____

Have you been under the care of a medical doctor or hospitalized during the past 2 years? Yes No

If so, please explain _____

Please list any medications or drugs you have taken in the past 2 years _____

Are you a smoker? Yes No

Please circle any of the following which you have had or have at present

- | | | |
|------------------------------|--------------------------|--------------------------|
| Heart failure | Hemophilia | Drug addiction |
| Heart disease/attack | Bleeding disorders | Epilepsy |
| Heart murmur | Blood transfusions | Fainting or dizzy spells |
| Mitral valve prolapse | Hepatitis A (infections) | Sickle cell disease |
| Artificial heart valve | Hepatitis B (serum) | Anemia |
| Heart pacemaker | High blood pressure | Glaucoma |
| Heart surgery/Bypass surgery | Radiation treatment | Alcoholism |
| Congenital heart lesions | Chemotherapy | Venereal disease |
| Organ transplants | Leukemia | AIDS or HIV positive |
| Artificial joints/implants | Psychiatric treatment | Kidney trouble |
| Rheumatic fever | Hay fever/sinus trouble | Ulcers |
| Diabetes | Emphysema/Asthma | Thyroid disease |
| Hypoglycemia | Tuberculosis | Arthritis |
| Blood thinners | Graves disease | Rheumatism |
| Birth control pills | Gout | Stroke |
| Steroids | Seizures | |

Are there any other medical concerns we should know about? _____

Have you ever had excessive bleeding requiring special treatment? Yes No

Are you pregnant, or do you anticipate becoming pregnant soon? Yes No

If so, how many months pregnant are you? _____ Dr.'s Name _____

ALLERGIES

Please circle the items to which you are allergic or cannot tolerate

- | | | |
|------------|-----------|--------------|
| Penicillin | Novocaine | Tetracycline |
| Codeine | Aspirin | Erythromycin |

Please list any other allergies or intolerances _____

OVER PLEASE

