MEDICAL HISTORY

NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE NUMBER (S)_____

_____ _____

IF ADULT – EMPLOYER _____

WORK PHONE _____

IS THERE ANY DENTAL INSURANCE? YES NO

PRIMARY COVERAGE

INSURANCE CO _____

EMPLOYER_____

EMPLOYEE _____

ID/SS# _____

GROUP/FILE # _____

SECONDARY INSURANCE

INSURANCE CO _____

EMPLOYER _____

EMPLOYEE _____

ID/SS# _____

GROUP/FILE # _____

WHO WILL PAY FOR THE ACCOUNT? _____

CIRCLE YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

RHEUMATIC FEVER	YES	NO	ARTIFICIAL LIMB OR JOINT	YES	NO
RHEUMATIC HEART DISEASE	YES	NO	HEPATITIS, JAUNDICE	YES	NO
CONGENITAL HEART LESIONS	YES	NO	LIVER DISEASE	YES	NO
CONGENITAL HEART DISEASE	YES	NO	ASTHMA	YES	NO
HEART MURMUR	YES	NO	ARTHRITIS	YES	NO
OPEN HEART SURGERY	YES	NO	KIDNEY TROUBLE	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	TUBERCULOSIS	YES	NO
ABNORMAL BLEEDING FROM CUTS	YES	NO	ULCERS	YES	NO
OTHER MAJOR SURGERY	YES	NO	HIGH BLOOD PRESSURE	YES	NO
FAINTING SPELLS	YES	NO	ANEMIA	YES	NO
CONTAGIOUS DISEASES (AIDS, VENEREAL)	YES	NO	PACEMAKER/ INTERNAL CARDIAC DEFIBRILLATOR	YES	NO
DIABETES	YES	NO	SEVERE INFECTIONS	YES	NO
CANCER	YES	NO	SEIZURES	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	STROKE	YES	NO
OSTEOPOROSIS	YES	NO			

PHYSICIAN(S) NAME(S) _____

ARE YOU UNDER HIS/HER CARE AT THIS TIME? _____

IF SO, FOR WHAT? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

PENCILLIN	YES	NO	CODEINE	YES	NO
ASPIRIN	YES	NO	LOCAL ANESTHETIC	YES	NO
LATEX ALLERGY	YES	NO			

LIST OTHER MEDICATION ALLERGIES: _____

DO YOU SMOKE OR CHEWTOBACCO? YES NO

IF YOU ARE TAKING ANY MEDICATIONS, PLEASE LIST: _____

_____

IF FEMALE, ARE YOU PREGNANT? YES NO ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

Anything else you would like us to know about your health? _____

Are there any improvements you would like to see in your smile? _____

WHO REFERRED YOU TO OUR OFFICE? _____

SIGNATURE _____ DATE _____

8/2011