WELCOME TO OUR OFFICE

Confidential Medical History

Patient's Name_____ Soc. Sec. No._____

Address_____ City, State, Zip_____

Phone No_____ Birth Date_____

Financial Information:

Responsible Party_____ Birthdate___/___/___ Phone No._____

Address_____ City, State, Zip_____

Soc. Sec. No_____ Insurance Carrier_____

Employed By_____ How Long?_____ Phone No._____

Address_____ City, State Zip_____

How did you hear about our office? _____

Please answer each of the following questions by placing an "X" under "Yes" or "No".	Yes	No
1. Are you in good health? Date of your last medical exam:___/___/___	☐	☐
2. Are you currently under the care of a physician? If yes, Physician's Name:_____ Physician's telephone number ( )_____	☐	☐
3. Have you ever had any major surgery, illness, or been hospitalized?	☐	☐
4. Are you taking any medicines or drugs of any kind?	☐	☐
5. (For women only) Are you pregnant? How many months:_____	☐	☐
6. Are you allergic to, or have you had, any bad reactions to local anesthetics or medicines?	☐	☐
7. Have you ever had any complications in connection with previous dental or oral surgery treatment?	☐	☐
8. Do you have high or low blood pressure?	☐	☐
9. Do you bleed easily or have anemia or hemophillia?	☐	☐
10. Have you ever had an artificial joint, heart pacemaker, or reheumatic fever?	☐	☐
11. Do you have a heart murmur or cardiac problems?	☐	☐
12. Have you tested positive for the HIV antibody or been diagnosed as AIDS or AIDS related complex?	☐	☐
13. Have you had, or are you now being treated for, a vereral disease: for example, syphilis or gonorrhea?	☐	☐
14. Have you ever had sinus trouble, asthma, bronchitis, tuberculosis, emphysema, or other lung disease?	☐	☐
15. Have you ever had hepatitis, jaundice, or other liver disease?	☐	☐
16. Have you ever had thyroid, kidney, or diabetic problems?	☐	☐
17. Have you ever been treated for mental or nervous disorders: for example, epilepsy, psychiatric treatment?	☐	☐
18. Please explain any "Yes" responses and list any conditions not covered above that your dentist should know about:		

I hereby consent to the treatment as agreed upon, to the taking of dental x-rays for diagnostic purposes, and to the use of local anesthetics, relaxants, gas or a conbination of both for completing the treatment.

Patient's Signature (or Parent, if Patient is a minor):_____ Date:___/___/___

Doctor's Signature:_____ Date:___/___/___

Medical History Updates

Date	Change	Patient's Signature	Doctor's Signature
___/___/___			
___/___/___			
___/___/___			