Date		

MEDICAL HISTORY FORM

Patient Information	on:										
Patient's Name:											
Address:		Last				F	irst				Middle Initial
, tadi 655	Address				City				State		Zip Code
Email Address:		:	SSN:			D	ate of Bi	rth:	/	/_	Age:
Sex: □ M □ F	Home No:				Cell No				_Alt. No: _		
Parent/Guardian	Insurance	Inforr	nation	Re	lationsl	ip to P	atient:_				_ □ SELF
Name:											
		Last					irst				Middle Initial
SSN:		lı	nsurance	e No.:			_ Driv	er Licer	nse No.:_		
Date of Birth:									Group N	o.:	
Employer:			Addr	ess: _					\		
Home No:											
Name and Number of How did you hear a					u:						
□ Online		Flyer / Mai		ciow.		☐ Printed	Ad		☐ Billi	board	
☐ Radio	_						nity Event				Screening
☐ Dr. Referral			Valking by th	ne Office		☐ Medicai					Employer
☐ Friend / Relative		Employee	3 ,								
Reason for today's	dental visit:					Date o	f last de	ental vi	sit:		
Have you ever had											
Please explain if yes	•		0.0								
Are you nervous about dental tre		Do your	gums bleed	, feel tend	ler or irritate	d?	Are	you unhap	py with appear	ance of y	our teeth?
☐ Yes ☐ No			☐ Yes ☐	□ No				☐ Yes	s □ No		
Are your teeth sensitive?		Do you	have discolo	red teeth	that bother y	ou?					
☐ Yes ☐ No			☐ Yes ☐	□ No							
If yes, to what?	ets 🗆 Hot	□ Cold	☐ Pre	ssure							
Are you now seeing a physician?		\square Yes	□ No	The nar	ne & telepho	ne number o	of your physic	ian(s)			
If so, what is the condition being	treated?										
Are you taking any medications?		☐ Yes	□ No	If yes, p	olease list: _						
Have you or are you currently tak			□ No								
If female, are you or do you suspe			□ No		·						
Have you or are you currently tak							☐ Skelif				
Have you had any joint replaceme				IT YES, W	/nen?	Voc. 🗆 I	No.				
Is there anything else we should I If yes, Please explain:	KIIOW ADOUL YOUI HE	dilli liidl W	gz Hor covere	20 011 11115	IOIIII: L	ies 🗀 i	NO				
Please mark any of	the followi	na wh	ich vou	have	had or	have a	t nreser	ht:		□ NC	NF
☐ Heart Disease	□ Ane		icii you	Have		ousness	t preser		□ HIV +		/IVE
☐ Heart Murmur		ney Tro	uble			oid Disea	ase		☐ Hepat		
☐ High Blood Pressur		ne Loss			☐ Chen	no: (Cancer	, Leukemia)		☐ Hemo	philia	
☐ Blood Disease	☐ Epil	epsy o	r Seizure	es	☐ Arth	itis			☐ Sickle	Cell D	Disease
□ Rheumatic Fever	☐ Ulce	ers			☐ Rheu	matism			□ Bruise	-	
☐ Venereal Disease	☐ Em	ohysem	na			sone Me			□ Pain ir		Joint
☐ Heart Pacemaker		erculos				Replace	ement		☐ Diabet		
☐ Asthma		rlet Fe			☐ Hay I	ever			☐ Glauce	oma	
Please mark any of		_	dical a	llergie						ON [NE
☐ Local Anesthetics	□ Pen						ther narc		☐ Fen-P		
☐ Aspirin		er antil					or sedati	ves	Other:		
□ Iodine		a Drug			□ Late				□ Other:		
To the best of my kno or if any medicines ci								. If I ev	er have a	ny cha	ange in my health
						-					
				. Madia	al Hictory	Undata:		Signatur ———	e of Patien	t/Pare	nt/Guardian
				riedica	al History	opuate:					

Dr.

Date

Dr.

Date

Dr.

Date