Medical History for:

First Name	Middle Initial	Last Name	Date of Birth
Address	City	State Zip	Phone

Physician (Include **first and last name** if possible):

Physician **Office Location/Contact number**:

Date of Last Physical:

Are you **under a physician's care**? YES NO

If so, **why**?

Have you ever **had an operation**? YES NO

If so, for **what and when**?

Do you have any **artificial joints**?	YES	NO
Do you have a **heart murmur**?	YES	NO
Do you have an **artificial heart valve**?	YES	NO
Have you ever had **Rheumatic Fever or Rheumatic heart disease**?	YES	NO
• **Women: Are you pregnant**?	YES	NO
• **Women: Are you taking Birth Control?**	YES	NO

Do you have, or have you ever had any of the following:

A. Anemia	YES	NO
B. Arthritis	YES	NO
C. Asthma	YES	NO
D. Diabetes	YES	NO
E. Epilepsy	YES	NO
F. Fainting Spells	YES	NO
G. Hay Fever	YES	NO
H. Heart attack	YES	NO
I. Hepatitis	YES	NO
J. High Blood Pressure	YES	NO
K. Hives or a skin rash	YES	NO
L. Jaundice of Liver Disease	YES	NO
M. Kidney Trouble	YES	NO
N. Low Blood Pressure	YES	NO
O. Seizures	YES	NO
P. Stomach Ulcers	YES	NO
Q. Stroke	YES	NO
R. Are you sensitive to metals and/or latex?	YES	NO
S. Do you have a pacemaker?	YES	NO
T. Have you tested positive to HIV?	YES	NO
U. Bled excessively after surgery or extractions?	YES	NO
V. Have you ever had a blood transfusion?	YES	NO
W. Have you ever had radiation or chemo?	YES	NO

(Please continue and finish Medical History form on backside)

Current Medications

Please list **NAME** of medication**, DOSAGE,** and **REASON** for medication**:**

1.	5.
2.	6.
3.	7.
4.	8.

Are you allergic to, or have you ever reacted adversely to, any of the follow?

Penicillin	YES	NO
Sulfa	YES	NO
Other Antibiotic:	YES	NO
Barbiturates, sedatives or sleeping pills	YES	NO
Local Anesthetics	YES	NO
Aspirin	YES	NO
Ibuprofen	YES	NO

Any Other?____

Dental History

Name of previous dentist/dental practice: ____

If you are a **New Patient**, date of **Last Dental Exam**:

Have you ever had any **serious trouble associated with previous dental treatment**? If so, **what**?	YES	NO
Have you ever had **orthodontic treatment** (braces):	YES	NO
Been treated for **gum disease** (gingivitis, periodontitis, pyorrhea):	YES	NO
Do you **grind or clench your teeth**?	YES	NO
Do you **smoke**, **chew**, **use snuff or any other forms of tobacco**?	YES	NO
Have you had a **skin reaction to rubber products or latex**?	YES	NO
Have you had any **injuries to your mouth or jaws**?	YES	NO
Have you been **satisfied with your previous dental care**? If not, please explain:	YES	NO

Is there **anything else we <u>should *know*</u> *about your health that we have not covered on this form***?

YES NO

If **YES**, please explain:

____ _____________________________

Signature **Date**

<u>Dental Insurance Plan Information</u>: **Name of Insurance Plan** ______________________________

Subscriber Name: ___________________________________ Subscriber's Birth Date: ________________________

Subscriber ID # or Social Security # _____________________ Group # _____________________________________

Ins. Mailing Address: ____

Phone # _____________________________________ Employer: ___________________________________