RECORD NUMBER

FOR OFFICE USE ONLY

PATIENT NAME_____ DATE_____

Address:_____ City:_____ State:_____ ZIP:_____

Birthdate:_____ Soc.Sec.#_____ ☐ Single ☐ Married ☐ Divorced ☐ Separated

Home phone:_____ Work phone:_____ ☐ Employed ☐ Student ☐ Homemaker ☐ Retired

Employer:_____ Ins.Co._____ Group #_____

Present position:_____ How long held:_____

Spouse (or other person responsible for payment) Name:_____ Soc.Sec.#_____

Address:_____ City:_____ State:_____ ZIP:_____

Employer:_____ Ins.Co._____ Group #_____

Present position:_____ How long held_____ Work phone:_____

Method of payment for dental care: ☐ Payment in full at each appointment. ☐ Insurance or prepaid program.

I first learned about this dental office from: ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work

Referred by: ☐ Another patient, friend. ☐ Another patient, relative. ☐ Dental office doctor or staff member.

☐ Other_____ Name of person who referred me:_____

DENTAL HISTORY

Have you been having any specific problems? ☐ Yes ☐ No Describe:_____

Last dental visit?_____ Purpose:_____ Last complete exam:_____

Has fear of discomfort kept you from regular visits? ☐ Yes ☐ No How do you describe your dental health? ☐ Good ☐ Fair ☐ Poor

Do you think you have active dental disease: Decay? ☐ Yes ☐ No Gum Disease? ☐ Yes ☐ No

Home care: Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No Water Jet? ☐ Yes ☐ No Other?_____

Do your gums ever bleed? ☐ Yes ☐ No How often?_____ Are you troubled with bad breath? ☐ Yes ☐ No

How do you feel about ever losing your teeth?_____

Have you had any unusual effects from previous dental treatment? ☐ Yes ☐ No Describe:_____

MEDICAL HISTORY (Confidential. Repeated every five years.)

MONTH/DAY/YEAR

Medical doctor's name:_____ Last physical exam:_____ Current age:_____

(Women) Are you pregnant? ☐ Yes ☐ No Expected delivery date:_____

Are you under a doctor's care now? ☐ Yes ☐ No If so, for what reason?_____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No Please list:_____

Have you ever had any of the following? Indicate YES with check mark (✓).

☐ Any heart problems.	☐ Measles.	☐ Diabetes.	☐ Hepatitis.	☐ Prosthetic valves/joints.
☐ High blood pressure.	☐ Mumps.	☐ Arthritis.	☐ Aids.	☐ Allergy to anesthetics:
☐ Low blood pressure.	☐ Scarlet fever.	☐ Malignancies.	☐ Venereal disease.	_____
☐ Circulatory problems.	☐ Typhoid fever.	☐ Radiation treatments.	☐ Herpes.	☐ Allergy to medicines/drugs:
☐ Excessive bleeding.	☐ Nervous problems.	☐ Asthma.	☐ Tuberculosis.	_____
☐ Anemia.	☐ Psychiatric care.	☐ Stroke.	☐ Sinus problems.	☐ Other allergies:
☐ Rheumatic fever.	☐ Hospitalization.	☐ Ulcer.	☐ Tonsilitis.	_____

Do you use tobacco products? ☐Yes ☐ No_____

Have you had any other serious illness? ☐ Yes ☐ No Explain:_____

Have you been hospitalized in the last two years? ☐ Yes ☐ No Why?_____

Have you ever had difficulty with anesthetics? ☐ Yes ☐ No Explain:_____

Do you wish to talk to the doctor about any problem not listed? ☐ Yes ☐ No Comments:_____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Patient Signature:_____ Date:_____

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B/P_____

Reviewed by: Doctor_____ Date:_____

MEDICAL HISTORY UPDATES FOR SUBSEQUENT VISITS

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditons.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B P	REVIEWED BY
_____	_____ None ☐	_____	_____	DR._____
_____	_____ None ☐	_____	_____	DR._____
_____	_____ None ☐	_____	_____	DR._____
_____	_____ None ☐	_____	_____	DR._____
_____	_____ None ☐	_____	_____	DR._____