PATIENT #

PATIENT'S NAME _____ Today's Date _____
Home Address _____ SSN _____
City, State, Zip _____ Date of Birth _____
Email _____ Home Phone _____
Patient's Employer _____ Work Phone _____
Driver's License # _____ Mobile Phone _____
General Dentist _____

INSURANCE COMPANY: _____ Phone _____
Subscriber Name _____ Date of Birth _____
Employer _____ Work Phone _____
SSN or ID# _____ Group# _____

IF PATIENT IS A MINOR:
Parent/Guardian Name _____ Home Phone _____
SSN _____ Date of Birth _____

Are you taking any medications? ☐ **Yes** ☐ **No** **Please List:** _____

MEDICAL HISTORY

Have you ever had? (Check box to left)

Yes	No		Yes	No	
☐	☐	Heart Murmur/MVP	☐	☐	Migraine/Headaches
☐	☐	Heart Disease	☐	☐	Currently Pregnant/Breast Feeding
☐	☐	Rheumatic Fever	☐	☐	Herpes
☐	☐	High Blood Pressure	☐	☐	Immunocomprised
☐	☐	Liver Disease	☐	☐	Chest Pain
☐	☐	HIV Positive	☐	☐	Radiation/Chemo Therapy
☐	☐	Diabetes	☐	☐	TMJ Problems
☐	☐	Lung Disease/Asthmas	☐	☐	Pacemaker
☐	☐	Excessive Bleeding	☐	☐	Prosthetic Implant
☐	☐	Thyroid Problems	☐	☐	Joint Replacement
☐	☐	Hepatitis	☐	☐	Arthritis
☐	☐	Tuberculosis	☐	☐	Heart Attack
☐	☐	Epilepsy	☐	☐	Stroke

Do you have any Allergies? ☐ **Yes** ☐ **No**

Aspirin	☐	☐
Penicillin	☐	☐
Local Anesthetic	☐	☐
Codeine	☐	☐
Latex	☐	☐

Please List: _____

Do you have any other medical conditions? _____
Are you under medical treatment now? _____
Have you had surgery in the past five years? _____
Do you premedicate or routinely take antibiotics before dental treatment? ☐ Yes ☐ No
Physician's Name _____ Phone _____
Notify in case of an emergency _____ Phone _____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have the opportunity to discuss my health history with the doctors and assistants.

X Signature of responsible party _____ **Date** _____

********PLEASE TURN OVER AND SIGN********

OFFICE USE ONLY

Date:	Date:	Date:	Date:	Date:	Date	Date:	Date:
Email:	Email:	Email:	Email:	Email:	Email:	Email:	Email:
Ltr: X P	Ltr: X P	Ltr: X P	Ltr: X P	Ltr: X P	Ltr: X P	Ltr: X P	Ltr: X P
Tooth:	Tooth:	Tooth:	Tooth:	Tooth:	Tooth:	Tooth:	Tooth:
Dr:	Dr:	Dr:	Dr:	Dr:	Dr:	Dr:	Dr:
Ast:	Ast:	Ast:	Ast:	Ast:	Ast:	Ast:	Ast:

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