PATIENT MEDICAL HISTORY

PATIENTS NAME:

ADDRESS: CITY STATE ZIP

HOME PHONE: CELL PHONE: BIRTHDATE: MARITAL STATUS:

SOCIAL SECURITY NUMBER: WHOM REFERRED YOU:

INSURANCE: POLICY HOLDER: POLICY HOLDER'S PLACE OF WORK:

SECONDARY INSURANCE: POLICY HOLDER: POLICY HOLDER'S PLACE OF WORK:

PREVIOUS DENTIST/OFFICE: DATE OF LAST VISIT: LAST XRAY'S TAKEN:

PHYSICIAN'S NAME: PHYSICIANS PHONE:

PHARMACY: PHARMACY PHONE:

SEX:

IF FEMALE PLEASE ANSWER THE FOLLOWING:

Y	N	
☐	☐	Are You Taking Birth Control Pills?
☐	☐	Are You Pregnant? If Yes, # Of Weeks
☐	☐	Are You Nursing?

PLEASE ANSWER THE FOLLOWING:

Y	N	
☐	☐	Do You Smoke Or Use Tobacco?

CONDITIONS:

Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Seizures	☐	☐	Stroke
☐	☐	Alcohol Abuse	☐	☐	Hay Fever	☐	☐	Thyroid Problems
☐	☐	Allergies	☐	☐	Heart Attack	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Heart Surgery	☐	☐	Yellow Jaundice
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis A			
☐	☐	Artificial Joints	☐	☐	Hepatitis B			
☐	☐	Asthma	☐	☐	Hepatitis C			
☐	☐	Cancer - Chemotherapy	☐	☐	High Blood Pressure			
☐	☐	Colitis	☐	☐	Kidney Problems			
☐	☐	Diabetes	☐	☐	Liver Disease			
☐	☐	Difficulty Breathing	☐	☐	Low Blood Pressure			
☐	☐	Drug Abuse	☐	☐	PRE - MED			
☐	☐	Emphysema	☐	☐	Pace Maker			
☐	☐	Epilepsy	☐	☐	Psychiatric Problems			
☐	☐	Fainting Spells	☐	☐	Radiation Therapy			
☐	☐	Glaucoma	☐	☐	Rheumatic Fever			
☐	☐	HIV+ AIDS	☐	☐	Sinus Problems			

Allergies:

☐Aspirin ☐Codeine ☐Dental Anesthetics ☐Latex
☐Metals ☐Erythromycin ☐Penicillin ☐Tetracycline
Others:

Medications:

SIGNATURE:________________________________ **DATE:**________________