MEDICAL HISTORY

PATIENT INFORMATION

Name: Last _____ First _____ Middle Initial _____ Sex: M ☐ F ☐
Social Security Number _____ Date of Birth _____ Age _____
If patient is a minor, give Parent's or Guardian's Name _____

RESPONSIBLE PARTY INFORMATION:

Name: Last _____ First _____ Middle Initial _____ Marital Status _____
Address _____ City _____ State _____ Zip _____
Mobile Phone _____ Home/Work Phone _____ Date of Birth _____
Email Address (to confirm appointments) _____
Driver's License No. _____ Social Security No._____
Occupation _____ Employer _____ # of Years Employed _____
Relationship to Patient: _____
Name/ Phone # of nearest relative not living with you _____

HOW DID YOU HEAR ABOUT US? PLEASE CHECK ALL THAT APPLY:

☐ Facebook / Twitter ☐ Friend / Relative ☐ Internet Search Engine ☐ Website
☐ Sign ☐ Employer ☐ Mailings ☐ Yelp

Reason for today's visit _____ Date of last dental visit _____
Have you ever had an experience in a dental office, which you would like to tell us about? Yes ☐ No ☐
If yes, please explain_____
Name / Number of your Medical Doctor_____
What medications are you taking now? _____
If female, are you pregnant? Yes ☐ No ☐ If yes, how long?
_____

Mark any of the following you have had in the past or present:

☐ ADHD	☐ Autism	☐ Epilepsy or Seizures	☐ Kidney Disease
☐ Aids/HIV+	☐ Auto Immune Disease	☐ Gastric Ulcers	☐ Liver Disease
☐ Anemia	☐ Blood Disease	☐ Heart Disease	☐ Mitral Valve Prolapse
☐ Arthritis, Rheumatism	☐ Cancer	☐ Heart Murmur	☐ Psychiatric Care
☐ Artificial Heart Valves	☐ Chronic Anxiety	☐ Heart Pacemaker	☐ Thyroid Disease
☐ Artificial Joint Replacement	☐ Cortisone Medicine	☐ Hepatitis	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ High Blood Pressure	Other_____

Mark any of the following medications you are allergic to:

☐ Clindamycin	☐ Latex Gloves	☐ Other Narcotics	☐ Sulfa Drugs
☐ Codeine	☐ Local Anesthetics	☐ Penicillin / Other Antibiotics	☐ Others _____

To the best of my knowledge, the questions on this form have been accurately answered. Also providing false information can be dangerous. It is my responsibility to inform the dental office of any changes in medical status.

_____
Signature of Patient / Parent / Guardian

HIPPA: Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

_____
Signature of Patient / Parent / Guardian

MEDICAL HISTORY UPDATED:

_____		_____		_____	
Dr. Signature	Date	Dr. Signature	Date	Dr. Signature	Date