

MEDICAL HISTORY

DATE _____
 NAME _____
 ADDRESS _____ APT. # _____
 CITY _____ STATE _____ ZIP _____
 PHONE _____ SOC. SEC. # _____
 OCCUPATION _____ PHONE _____
 WORK ADDRESS _____
 BIRTHDATE _____ SEX: _____ M _____ F
 SPOUSE _____ NO. OF CHILDREN _____
 PARENT OR GUARDIAN (IF UNDER 18) _____

DENTAL INSURANCE:
 1. _____
 2. _____
 WHO WILL PAY FOR THIS ACCOUNT? _____
 REFERRED BY _____
 PHYSICIAN NAME _____
 PHYSICIAN ADDRESS _____
 PHYSICIAN PHONE NO. _____
 REASON FOR DENTAL VISIT _____

UPDATES: Date _____ Date _____ Date _____
 Dr. Signature _____ Dr. Signature _____ Dr. Signature _____

MEDICAL HISTORY: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. **HAVE YOU EVER HAD OR HAVE:**

		YES	NO
1. Asthma, hay fever, sinusitis, or other allergies			
2. Allergy to penicillin, aspirin, local or general anesthetic, or other drugs; specify:			
3. Blood pressure or heart problems			
4. Rheumatic fever or heart murmur			
5. A pacemaker or open heart surgery			
6. Diabetes, liver, kidney, thyroid, or lung problems			
7. Ulcers or stomach problems			
8. Hepatitis or Jaundice			
9. Epilepsy or nervous disorders			
10. Bleeding or clotting disorders			
11. Arthritis			
12. Venereal Disease, Herpes			
13. Acquired Immune Deficiency Syndrome (AIDS)			
14. Any other illness			
15. Do any wounds heal slowly or present complications?			
16. Are you presently taking any medicine? Specify:			
17. Are you presently under the care of a physician?			
18. When was your last physical exam?			
19. Have you ever been hospitalized? Date: _____ Reason: _____			
20. Have you had X-ray treatments or chemotherapy?			
21. Are you presently on a diet?			
22. Women: () Are you taking birth control pills? () Are you pregnant?			

In the event that the insurance company does not honor a claim, or if an error in assignment of benefits is made, I understand that I am fully responsible for payment of services rendered.

PATIENT SIGNATURE _____ DATE _____ DOCTOR SIGNATURE _____ DATE _____