

Name _____ Date of Birth _____ Marital Status _____ Social Security No. _____
 First MI Last

Home Address _____ City _____ State _____ Zip _____

Home ph# _____ Alt. ph# _____ Employer _____

Dentist _____ Family Physician _____

Dental Insurance _____ Primary Holder _____

ID No. _____ Primary Holder's Date of Birth _____ Relationship to Primary Holder _____

(or Primary Holder's Social Security No)

Person Responsible for payment _____ Relationship _____

How will payment be made today? Cash Check Credit Card *KEEP CREDIT CARD ON FILE? ___ YES or ___ NO*

Medical History

(Please circle yes or no)

Are you in good health?YES NO

How long ago was your last physical exam? _____

Any changes in health since last year?YES NO

Have you had major or minor surgery in the past 5 years?YES NO

Are you being treated by a physician?YES NO

If so, for what condition? _____

Are you now taking any drug or medication?YES NO

If so, what medication? _____

Have you ever had an injury to the face, head, mouth, or teeth?YES NO

Please explain _____

Have you ever had any of the following? *(please circle yes or no)*

High blood pressure.....	YES	NO	Syphilis/Gonorrhea.....	YES	NO	Epilepsy.....	YES	NO
Low blood pressure.....	YES	NO	Thyroid disease.....	YES	NO	Sexually transmitted		
Rheumatic fever.....	YES	NO	Psychiatric treatment			disease.....	YES	NO
Heart murmur.....	YES	NO	or mental disorders.....	YES	NO	Herpes.....	YES	NO
Heart condition.....	YES	NO	Diabetes.....	YES	NO	Cold Sores.....	YES	NO
Artificial valve.....	YES	NO	AIDS/HIV positive.....	YES	NO	Hay fever.....	YES	NO
Blood transfusion.....	YES	NO	Cancer.....	YES	NO	Arthritis.....	YES	NO
Heart pacemaker.....	YES	NO	Chemotherapy.....	YES	NO	Asthma.....	YES	NO
Artificial joint.....	YES	NO	Lung disease.....	YES	NO	Glaucoma.....	YES	NO
Kidney disease.....	YES	NO	Anemia.....	YES	NO	Tuberculosis.....	YES	NO
Hepatitis or jaundice.....	YES	NO	Abnormal bleeding.....	YES	NO	Steroid or hormonal therapy....	YES	NO
Allergies.....	YES	NO	Alcoholism.....	YES	NO	Stomach or		
Sinus trouble.....	YES	NO	Drug addiction.....	YES	NO	intestinal disorders.....	YES	NO
Stroke.....	YES	NO	Nervous disorders.....	YES	NO	Fibromyalgia.....	YES	NO

Have you ever had an allergic or unusual reaction to any of the following? *(Please circle Yes or No)*

Dental local anesthetics.....	YES	NO	Penicillin.....	YES	NO
Aspirin or Tylenol compounds.....	YES	NO	Erythromycin or other antibiotics.....	YES	NO
Codeine or other narcotics.....	YES	NO	Any other drug or medication.....	YES	NO
Barbituates or tranquilizers.....	YES	NO	Latex.....	YES	NO

Is there anything that the dentist should know regarding your medical history that has not been mentioned?.....YES NO

Please explain _____

Women Are you pregnant?.....YES NO If yes, how many months? _____
 Do you anticipate becoming pregnant?.....YES NO
 Are you taking birth control pills?.....YES NO
 If you have an infant, are you breastfeeding?.....YES NO

To the best of my knowledge all of the proceeding answers are true and correct. If I ever have any change in my health or in my medication I will inform the dentist without fail.

SIGNED: _____ DATE: _____
(parent or guardian, if minor)

MEDICAL HISTORY UPDATE
Addition or change

Date _____ Signature _____

Reviewed by Doctor _____