Date:

PATIENT MEDICAL HISTORY

First Name: M.I. Last Name: Birthdate:

Sex: ☐ Male ☐ Female

Physician Name (Medical Doctor) Physician's Phone:

In case of Emergency, who should be contacted?

Emergency Contact Phone Number: Relationship:

If Female, Please Answer the Following:

☐ Yes ☐ No Are you Pregnant? If yes, # of weeks:

☐ Yes ☐ No Are you Nursing?

Please Answer the Following:

☐ Yes ☐ No Do You Smoke or Use Tobacco?

Height:

Weight:

Do you have any of the following medical conditions and/or been treated for them?

Y	N		Y	N		Y	N	
☐	☐	Alcohol Abuse	☐	☐	Gastrointestinal Problems	☐	☐	Mental Health Conditions
☐	☐	Anemia	☐	☐	Hearing Loss	☐	☐	Nervous Disorder
☐	☐	Angina/Chest Pain	☐	☐	Heart Disease/Heart Attack	☐	☐	Osteoporosis
☐	☐	Arthritis	☐	☐	Heart Mumur/Mitral Valve Prolapse	☐	☐	Pace Maker
☐	☐	Asthma/Difficulty Breathing	☐	☐	Hemophilia	☐	☐	Rhuematic Fever
☐	☐	Autoimmune Disorder	☐	☐	Hepatitis	☐	☐	Seizures/Epilepsy
☐	☐	Cancer/Chemo/Radiation	☐	☐	Herpes	☐	☐	Significant Weight Loss
☐	☐	Cardiovascular Disease	☐	☐	High Blood Pressure	☐	☐	Sinus Trouble
☐	☐	Congenital Heart Defect	☐	☐	HIV/AIDS	☐	☐	Special Needs
☐	☐	Development Disabilities	☐	☐	Joint Replacement	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Kidney/Bladder Trouble	☐	☐	Thyroid Problems
☐	☐	Drug Abuse	☐	☐	Leukemia	☐	☐	Tuberculosis
☐	☐	Emphysema/COPD	☐	☐	Liver Disease	☐	☐	Ulcers
☐	☐	Fainting Tendency	☐	☐	Low Blood Pressure	☐	☐	Venereal Disease
☐	☐	Frequent Heaches	☐	☐	Memory Changes	☐	☐	Vision Changes

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine	☐	☐	Tetracycline
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Others
☐	☐	Codeine	☐	☐	Penicillin			
☐	☐	Gluten	☐	☐	Sulfa			

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

☐ Yes ☐ No Are you under the care of a physician now?

☐ Yes ☐ No Have you been hospitalized for any surgical operation or serious illness within the last five years?

☐ Yes ☐ No Have you been advised to take anitbiotics prior to having your teeth cleaned?

Is there any disease, condition, or problem that you think this office should know about that is not covered above? Please describe below:

Preferred Pharmacy:

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examintion, rendered to me or my child during the period of such dental care, to third party payors and/or health practioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. There will be a $45 charge for appointments cancelled without 24 hour notice.

Patient Signature