Dental & Medical History

Name_____ Date of Birth _____
Last First

Address_____
Street City Zip

Phone- Home_____ Work _____ Cell_____ E-Mail_____

Case of Emergency, Please Contact _____ Phone _____
Name

Whom may we thank for this referral? _____

Employer _____ Employer_____

Dental Insurance Primary Carrier Name:_____ Group#____ ID#_____

Subscriber name _____ DOB_____

Secondary Carrier Name_____ Group #_____ ID#_____

Subscriber Name_____ DOB_____

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1. Do you have a specific dental problem or complaint? YES NO
2. If so, please describe briefly _____
3. Do you have dental exams on a regular basis? YES NO
4. Date of your last visit. _____
5. Have you ever had orthodontic treatment (braces)? YES NO
6. Do you require antibiotic premedication prior to dental treatment? YES NO

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1. Physician's name _____
   Address _____ Phone _____
2. When was your last complete physical exam? _____
3. Are you taking any medication or substances? _____ YES NO
   If so, please list _____
   _____
   _____
4. Are you currently taking any herbal or homeopathic remedies? _____ YES NO
   If so, please list _____
5. Are you allergic to any medications or substances? _____ YES NO
   If so, please list_____
6. Are you sensitive to any metals or latex? _____ YES NO
7. Have you ever been treated for or told you might have any of the following: (Please Circle)

Heart Disease	Diabetes	Liver Problems	Kidney Problems
Heart Murmur	Leukemia	Hepatitis	Ulcers
Artificial Heart Valve	Anemia	HIV Positive	Epilepsy
Rheumatic Fever	Asthma	AIDS	Venereal Disease
High Blood Pressure	Artificial Joint	Arthritis	Alcoholism
Cancer	Radiation Therapy	Chemotherapy	Stroke

8. Have you ever had any major surgery? _____ YES NO
   If so, please explain _____
9. Do you smoke, chew, use snuff, or any other form of tobacco? _____ YES NO
10. Have you had psychiatric treatment? _____ YES NO
11. Are you pregnant or suspect you may be? _____ YES NO
12. Do you use any birth control medications? _____ YES NO
13. Do you have any disease, conditions or problems not listed? _____ YES NO
    If so, please explain _____
14. Would you like to speak to the doctor privately about any problems _____ YES NO

I certify that the above information is complete and accurate.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE_____