MEDICAL-DENTAL HISTORY FORM

Name _____
Last First Middle

Address: _____City _____ State _____ Zip Code_____

Secondary Address (**if applicable**): _____

Preferred Name: _____ SS#: _____ DOB:_____

Sex: _____ Marital Status: _____

IF WE ARE UNAUTHORIZED TO LEAVE MESSAGES AT ANY OF THE NUMBERS OR E-MAIL ADDRESS LISTED BELOW PLEASE MARK HERE, OTHERWISE WE WILL ASSUME WE ARE ABLE. ☐

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Medical Alerts: _____

Are you now or have you recently been under a physician's care? YES NO

Have you ever been a patient in a hospital or had any serious illness? Explain:

_____

Check any of the following that you have had or suspected:

□ High/Low Blood Pressure	□ Hepatitis or Jaundice	□ Prolonged Bleeding
□ Rheumatic Fever	□ Liver Disease	□ Blood Transfusion
□ Heart Trouble	□ Epilepsy	□ Mental Disorder
□ Heart Murmur	□ Tuberculosis	□ Thyroid Disease
□ Arthritis	□ Diabetes	□ Sinus Trouble
□ Kidney/Bladder Trouble	□ Blood Disease	□ Prosthetic Joint Replacement
□ Stroke	□ Anemia	
□ Lung Disease	□ HIV or AIDS	□ Cancer/Tumor/Radiation Treatment
□ Asthma or Hay Fever	□ Venereal Disease	

Check any of the following that you are taking or have taken:

□ Cortisone Drugs	□ Anticoagulants	□ Fosamax	□ Tranquilizers
□ Steroids	□ Blood Thinners	□ Fen-phen	□ Sedatives

Are you taking other medications? Explain: _____

Are you allergic to or do you suffer ill effects from any of the following?

□ Penicillin	□ Codeine	□ Dental Anesthesia
□ Aspirin	□ Household Bleach	□ Latex
□ Other _____		

WOMEN ONLY:
Are you pregnant? YES or NO, If yes how many months? _____ Are you breast feeding? _____

Are you presently taking medicine of any kind routinely? (Birth control pills, shots,implants, hormone therapy, etc.)

Explain: _____

THE ABOVE INFORMATON IS TRUE TO THE BEST OF MY KNOWLEDGE.

RESPONSIBLE PARTY NAME (PRINT): _____

Signature:_____ Date: _____