MEDICAL HISTORY

PURPOSE OF THIS VISIT _____

ARE YOU HAPPY WITH YOUR SMILE? _____

OTHER DENTAL COMPLAINTS _____

WHAT TYPE OF MUSIC DO YOU LIKE? _____

IS THERE ANYTHING WE CAN DO TO MAKE YOUR VISIT MORE COMFORTABLE? _____

WHEN DID YOU LAST SEE A DENTIST? _____ FOR WHAT REASON? _____

ARE YOU TAKING ANY MEDICATIONS? IF SO, PLEASE LIST.

_____ _____

_____ _____

Referred by: _____

ARE YOU ALLERGIC TO...?

PENICILLIN	Y	N	LOCAL ANESTHETIC	Y	N	ASPIRIN	Y	N	LATEX	Y	N
CODEINE	Y	N	OTHER, EXPLAIN	Y	N	_____					

DO YOU HAVE / DID YOU EVER HAVE...?

RHEUMATIC FEVER	Y	N	DIABETES	Y	N	HEPATITIS	Y	N
ASTHMA	Y	N	ARTIFICIAL JOINTS / BODY PARTS	Y	N	EPILEPSY	Y	N
TUBERCULOSIS	Y	N	ANEMIA	Y	N	PACEMAKER	Y	N
HEART MURMUR	Y	N	ABNORMAL BLOOD PRESSURE	Y	N	ABNORMAL BLEEDING	Y	N
ABNORMAL HEART CONDITION	Y	N	HERPES OR VENEREAL DISEASE	Y	N	HIV/AIDS	Y	N
OTHER, EXPLAIN	Y	N	_____					

ARE YOU PREGNANT? Y N

NAME OF YOUR PHYSICIAN _____ PHONE NUMBER _____

DATE OF LAST MEDICAL EXAM _____ REASON FOR EXAM _____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? _____ WHY? _____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS, OR OTHER MEDICAL OR DENTAL INFORMATION THAT THE DOCTOR SHOULD KNOW ABOUT: _____

_____

PATIENT SIGNATURE _____ DATE _____

GUARDIAN OR PARENT SIGNATURE (IF MINOR) _____

Payment Method

Cash ☐ Credit Card ☐

MC/Visa/Discover/AMX # _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Signature _____

DATE