Patient Information

Date _____

Full Name _____ Birth Date _____ Marital Status _____
Home Address _____ Zip _____ Home Phone _____
Occupation _____ Employer _____ Social Security No. _____
Business Address _____ Zip _____ Work Phone _____
Name of Spouse _____ Occupation _____ Employer _____
Dental Insurance Company _____ Policy No. _____
Referred By _____ Previous Dentist _____
Name of Physician _____ Phone No. _____
In Case of Emergency Contact _____ Phone No. _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No
1. Have you ever been hospitalized, major operations or serious illness? If so, what? _____	☐	☐
2. Are you under any medical treatment now?	☐	☐
3. Have you had any allergic reactions to any drugs including penicillin, codeine, novocaine, aspirin?	☐	☐
4. Has there been a change in your health in the past year?	☐	☐
5. Have you ever had a blood transfusion?	☐	☐
6. Have you ever had kidney dialysis treatment?	☐	☐
7. Have you ever had abnormal bleeding problems after a cut or tooth extraction?	☐	☐
8. Are you now taking drugs or medications? If so, what? _____	☐	☐

9. Has a physician ever informed you that you had:

	Yes	No		Yes	No
Heart Ailment	☐	☐	Hepatitis or Yellow Jaundice	☐	☐
High Blood Pressure	☐	☐	Liver Disease	☐	☐
Rheumatic Fever	☐	☐	Venereal Disease	☐	☐
Heart Murmur	☐	☐	AIDS	☐	☐
Mitral Valve Prolapse	☐	☐	Stomach or Intestinal Disease	☐	☐
Angina	☐	☐	Kidney Disease	☐	☐
Stroke	☐	☐	Tumors or Growths	☐	☐
Blood Disease	☐	☐	Diabetes	☐	☐
Hemophilia	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Respiratory Disease	☐	☐
			Epilepsy	☐	☐

10. Women: A. Are you pregnant? ☐ ☐
B. Estimated Date of Delivery _____

Medical History Summary

Blood Pressure:

Signature _____ Date _____

Updating _____

FORM 219634 ITEM 8101