PATIENT INFORMATION AND MEDICAL HISTORY

DATE ______

NAME ______ (LAST / FIRST / M) ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE

SS# ______

ADDRESS ______ (STREET / APT.# / CITY / STATE / ZIP)

BIRTHDATE ______ (MONTH / DAY / YEAR) TELEPHONE ______ (HOME# / WORK# / FAX# / E-MAIL#)

PLACE ... OYMENT ______ ADDRESS ______

... ENT, SCHOOL NAME ______ GRADE ______

... LE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPO... ☐...THER ☐MOTHER

... ATION

... ETE FOR RESPONSIBLE PARTY

GENERAL CONSE...

I hereby authorize ... group insurance benefit... responsible for ... Dental Offic... diagnostic... necessary... dental... the ri... info... h...

Who? ______ Phone ______ Yes No

Ever taken fen-phen?* ______ Yes No

... x below ______ Yes No

... x Rubber ☐ Other ______

... ursing ☐ Taking oral contraceptives Discuss ______ Yes No

... g? Please check appropriate boxes.

... r to your appointment... premedication may be required.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
... Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
... Cell Disease	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Hemophilia (Bleeding Problem)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐
Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness	☐	☐
Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma	☐	☐
Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths	☐	☐
Breathing Problem	☐	☐	Diabetes	☐	☐	Artificial Joint *	☐	☐	Nervousness	☐	☐
Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Alzheimer's Disease	☐	☐
Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies (Medicines)	☐	☐
Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	Genital Herpes	☐	☐	Allergies (Pollen / Dust)	☐	☐
Asthma	☐	☐	Hepatitis B or C	☐	☐	Drug Addiction/Alcoholism	☐	☐	Hives or Rash	☐	☐
Bloody Sputum	☐	☐	Night Sweats	☐	☐	Tattoos	☐	☐	Need Premedication?	☐	☐

Partly legible entries in the leftmost column: ... Valve *, ... Pace Maker *, ... rt Surgery, High Blood Pressure, Low Blood Pressure, Blood Disease, Unexplained Fever

Have you ever had any other serious illness not checked above? Discuss ______ Yes No

Do you wish to talk to the dentist privately about any problem? ______ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ______ Date ______

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor ______ Date ______ BP ______

History Review and Significant Findings ______

PATIENT NAME ______ ACCOUNT # ______

Date	Acct.	Tooth #	Surfaces		Provider Signature	ADA Code	Fee