PATIENT NAME _____ DATE _____

Address:_____ City:_____ State:_____ Zip:_____
Birthdate:_____ Soc. Sec.#_____ ☐ Single ☐ Married ☐ Divorced ☐ Separated
Home phone:_____ Work phone:_____ ☐ Employed ☐ Student ☐ Homemaker ☐ Retired
Employer:_____ Ins. Co._____ Group #_____
Present position:_____ How long held:_____
Spouse (or other responsible person) Name:_____ Birthdate:_____Soc. Sec.#_____
Address:_____ City:_____ State:_____ Zip_____
Employer:_____ Ins. Co._____ Group #_____
Present Position:_____ How long held_____ Work phone_____
Method of payment for dental care: ☐ Payment in full at each appointment. ☐ Insurance or prepaid program.
In case of emergency call: Name:_____ Number_____
I first learned about this dental office from: ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work
Referred by: ☐ Another patient, friend ☐ Another patient, relative. ☐ Dental office doctor of staff member.

☐ Other_____ Name of person who referred me:_____

DENTAL HISTORY
Have you been having any specific problems? ☐ Yes ☐ No Describe:_____
Last dental visit?_____ Purpose:_____ Last complete exam:_____
Has fear of discomfort kept you from regular visits? ☐ Yes ☐ No How do you describe your dental health? ☐ Good ☐ Fair ☐ Poor
Do you think you have active dental disease: Decay? ☐ Yes ☐ No Gum Disease? ☐ Yes ☐ No
Home care: Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No Water Jet? ☐ Yes ☐ No Other?_____
Do your gums ever bleed? ☐ Yes ☐ No How often?_____ Are you troubled with bad breath? ☐ Yes ☐ No
How do you feel about ever losing your teeth?_____
Have you had any unusual effects from previous dental treatment? ☐ Yes ☐ No Describe:_____

MEDICAL HISTORY (Confidential. Repeated every five years.) MONTH/DAY/YEAR_____
Medical doctor's name:_____ Last physical exam:_____ Current age:_____
(Women) Are you pregnant? ☐ Yes ☐ No Expected delivery date:_____
Are you under a doctor's care now? ☐ Yes ☐ No If so, for what reason?_____
Are you taking any medications, pills or drugs? ☐ Yes ☐ No Please list:_____
Have you ever had any of the following? Indicate YES with check mark (✓).

☐ Any heart problems.	☐ Measles.	☐ Diabetes.	☐ Hepatitis.	☐ Prosthetic valves/joints
☐ High blood pressure.	☐ Mumps.	☐ Arthritis.	☐ AIDS.	☐ Allergy to anesthetics:
☐ Low blood pressure.	☐ Scarlet fever.	☐ Malignancies.	☐ Venereal disease.	_____
☐ Circulatory problems.	☐ Typhoid fever.	☐ Radiation treatments.	☐ Herpes.	☐ Allergy to medicines/drugs:
☐ Excessive bleeding.	☐ Nervous problems.	☐ Asthma.	☐ Tuberculosis.	_____
☐ Anemia.	☐ Psychiatric care.	☐ Stroke.	☐ Sinus problems.	☐ Other allergies_____
☐ Rheumatic fever.	☐ Hospitalization.	☐ Ulcer.	☐ Tonsillitis.	☐ Heart murmur.

Have you had any other serious illness? ☐ Yes ☐ No Explain:_____
Have you been hospitalized in the last two years? ☐ Yes ☐ No Why?_____
Have you ever had difficulty with anesthetics? ☐ Yes ☐ No Explain:_____
Do you wish to talk to the doctor about any problem not listed? ☐ Yes ☐ No Comments:_____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Patient Signature:_____ Date_____

FOR OFFICE USE ONLY

Reviewed by: Doctor_____ Date_____ B/P_____

MEDICAL HISTORY UPDATES FOR SUBSEQUENT VISITS
I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____