MEDICAL & DENTAL HISTORY

NAME OF PATIENT

Date of Birth **Social Security #**

Home Phone # **Cell #**

E-Mail

Address **City** **Zip Code**

Contact in case of Emergency **Telephone**

Who is responsible for this account?

Which Insurance is available?

Name of Insured? **Relationship**

Date of Birth of the Insured? **Identification #**

Place of Work **Occupation**

Address at Work

Telephone at Work **Group #**

Please answer the following questions correctly in order to aid your dentist in planning your treatment

Circle one YES or NO

1. Are you currently being treated by a physician? **Yes No**

If yes, Why are you being treated?

2. Are you taking any prescription medicine? **Yes No**

Which ones and what quantity?

3. Have you had any heart surgery? **Yes No**

4. Do you have a heart murmur? **Yes No**

5. Have you ever had a heart attack? When? **Yes No**

6. Do you have a pacemaker or any metal in your heart valves? **Yes No**

7. Do you need to be premedicated before receiving any dental treatments? **Yes No**

8. Are you allergic to any medicine? If **Yes No**

If Yes, which ones

9. Do you have or have you ever had any of the following illnesses or problems? Please mark Yes or No

	Yes	No		Yes	No		Yes	No
Hemophilia	☐	☐	Rheumatism	☐	☐	Uncontrolled Nervousness	☐	☐
Abnormal Bleeding	☐	☐	Kidney	☐	☐	Mental Disorder	☐	☐
Anemia	☐	☐	Hip	☐	☐	Celebral Palsy	☐	☐
Hepatitis A , B, C	☐	☐	Artificial Prothesis	☐	☐	Cortisone Treatment	☐	☐
Celebral Spill	☐	☐	Tuberculosis	☐	☐	Thyroid	☐	☐
High Blood Pressure	☐	☐	Efisima	☐	☐	Drug Addiction	☐	☐
Chest Pain	☐	☐	Asthma	☐	☐	Blood Transfusion	☐	☐
Arthritis	☐	☐	Rheumatic Fever	☐	☐	Blood Disease	☐	☐
Liver	☐	☐	Epilepsy/Seizures	☐	☐	Chemotherapy	☐	☐
Cancer	☐	☐	Diabetes	☐	☐	Radiation	☐	☐
Ulcers	☐	☐	Glaucoma	☐	☐	Venereal Disease	☐	☐
Headaches	☐	☐	AIDS/ HIV virus	☐	☐	Alcohol/ Smoke	☐	☐

10. Do you have any disease or problem not listed above? **Yes No**

If you answered Yes, please Explain

Women:

Are you pregnant? Yes No **Are you breast feeding? Yes No** **Are you taking Birth Control? Yes No**

Signiture of Patient or Legal Guardian **Today's Date**