

So that we may customize your dental care to your needs, we ask that you provide the following information:

PERSONAL INFORMATION Name: Please circle one: Dr. Mr. Mrs. Ms. Miss Birthdate: Address: _____ State: Zip: City: Home Phone: () Employer: Business Address: State: Zip: Work Phone: () Spouse's Name: _____ Spouse's Birthdate: _____ Children's Names & Ages: Spouse's Employer: _____ Occupation: ____ Business Address: State: Zip: Work Phone : () Note: INSURANCE INFORMATION Insurance Company: Address: State: Zip: City: Policy/Group Number: _____ Subscriber Social Security Number: Second Insurance Company: Address: _____ State: Zip: City: Policy/Group Number: _____ Subscriber Social Security Number: EMERGENCY Who should we contact in case of emergency? Name: Address: State: Zip: Phone : () _____ Who can we thank for referring you to our office?

MEDICAL HISTORY

4	What is the main reason for today's y	icit?			YES	NO	
2	Are you having pain or discomfort at	this tim	e?				
	Do you feel very nervous about having dentistry treatment?						
5	. Have you been under the care of a medical doctor during the past two years?						
	6. Are you presently taking any medicine or drugs?						
	If so, please list:						
7.	Are you allergic to (i.e. itching, rash, s	swelling	of hands, feet or eyes) or made sick b	ру			
	penicillin, aspirin, codeine, or any dru	gs or m	nedicine?				
	If so, please list:						
	Are you a smoker?						
	☐ Heart Failure		Emphysema		AIDS/HIV Positive		
	Heart Disease or Attack		Tuberculosis (TB)		Hepatitis Type:		
	Angina Pectoris		Asthma		Liver Disease		
	High Blood Pressure		Hay Fever		Yellow Jaundice		
			Sinus Trouble		Blood Transfusion		
			Allergies or Hives		Drug Addiction		
	Congenital Heart Lesions		Diabetes Thyroid Disease			orrhoa	
	Artificial Heart Valve		Thyroid Disease		Cold Sores	ioiiiiea,	
	Heart Pacemaker		X-ray or Cobalt Treatment		Epilepsy or Seizures		
	Heart Surgery		Chemotherapy (Cancer, Leukemia)				
	☐ Artificial Joint		Arthritis		Fainting or Dizzy Spells .		
	Anemia		Rheumatism		Nervousness		
	Stroke		Cortisone Medicine		Psychiatric Treatment		
	☐ Kidney Trouble		Pain in Jaw Joints		Bruise Easily YES	NO	
14. 15. 16. 17. 18.	Do you ever wake up from sleep shoth Are you on a special diet?	ort of brown to the process of the p	eath? e cancer or a tumor? have you been treated for chemical depolem not listed, or is there anything else eng answers are true and correct. If I eventist or hygienist at the beginning of my in	endendende the d	acy?	lition,	
Dat	re Signatu	re of Pa	atient, Parent or Guardian				
No	es:						
INO	65.						
			Medical History Update				
Date	Addition		Date Addition		Date Addition		
						-	