Patient Medical History

Physician_____

Approximate date of last physical exam_____

	Yes	No
1. Are you under any medical treatment now_____	☐	☐
2. Have you had any medical operations? if so what?_____	☐	☐
3. Have you ever had a serious accident involving head injury? _____	☐	☐
4. Have you had any allergic reactions to any drugs including penicillin? _____	☐	☐
Has a Physician ever informed you that you had:		
5. A Heart Ailment?_____	☐	☐
6. High Blood Pressure? _____	☐	☐
7. Respiratory Disease? _____	☐	☐
8. Diabetes?_____	☐	☐
9. Rheumatic Fever? _____	☐	☐
10. Rheumatism or Arthritis?_____	☐	☐
11. Tumors or Growths? _____	☐	☐
12. Any Blood Diseases?_____	☐	☐
13. Any Liver Diseases? _____	☐	☐
14. Any Kidney Diseases?_____	☐	☐
15. Any Stomach or Intestinal Diseases?_____	☐	☐
16. Any Venereal Diseases? _____	☐	☐
17. HIV Positive? _____	☐	☐
18. Yellow Jaundice or Hepatitis? _____	☐	☐
19. Do you have night sweats accompanied by weight loss or cough?_____	☐	☐
20. Medications Taken Presently?_____	☐	☐
21. Are you allergic to any known materials resulting in hives, asthma, eczema?_____	☐	☐
22. Are you in general good health at this time_____	☐	☐
23. Have any wounds healed slowly or presented other complications?_____	☐	☐
24. Are you pregnant? _____	☐	☐
25. Do you have a history of fainting? _____	☐	☐
26. Are you on a diet at this time? _____	☐	☐
27. Have you ever had any X-Ray treatments (other than diagnostic)? _____	☐	☐

Patient Information For Adults

Patients Name_____Preferred First Name_____Sex: M F

Home Address_____

Length of time at this address_____ Home Phone_____

Driver License #_____

Date of Birth_____ Social Security Number_____

Patients Dentist_____Referred By_____

Date of Last Dental Exam_____

Any unusual Dental Experiences?_____

Employer_____Business Phone_____

Occupation_____Length of Employment_____

Marital Status: Single Married Separated Divorced Widowed Remarried

Have any family members been a patient Yes No Name_____

Name of Spouse_____

Spouse's Employer_____Spouse's Business Phone_____

Spouse's Business Address_____

Spouse's Occupation_____Length of Employment_____

Please complete the following information on the person responsible for payment of the account if other than the patient:

Person Responsible for payment of account_____

Relationship to Patient _____

Home Address _____

Length of time at this address_____Home Phone_____

Mailing Address_____

Driver's License # _____

Social Security Number _____

Business Address_____

Business Telephone _____

Occupation _____Length of Employment_____

Persons other than those listed above that you wish to be informed of treatment or financial information: _____

Person to be notified in case of emergency:_____

Are you covered by orthodontic insurance? Yes No

Name of Insured _____Social Security Number_____

Name of Insurance Company_____ Phone_____

Group # _____Policy # _____

I understated that, where appropriate, credit bureau reports may be obtained

Signature _____ Date _____