Patient Medical History

Patient's Name: Today's Date:

Address: City, State, Zip:

Email Address:

Home Phone #: Mobile Phone #: Work Phone #:

Birth Date: SSN: Marital Status:

Primary Dental Guarantor:

Home Phone #: Mobile Phone #: Work Phone #:

Secondary Dental Guarantor:

Home Phone #: Mobile Phone #: Work Phone #:

Primary Physician's Name: Phone #:

Pharmacy: Phone #:

Sex: If Female, check if you are:

☐ Pregnant (if "Yes," number of weeks:), ☐ Taking birth control pills, ☐ Nursing

Do you smoke or use tobacco? If "Yes," for how long:

Please select any of the following conditions you have or have had:

☐ Abnormal Bleeding	☐ Colitis	☐ Heart Attack	☐ Psychiatric Problems
☐ Alcohol Abuse	☐ Congenital Heart Defect	☐ Heart Surgery	☐ Radiation Therapy
☐ Allergies	☐ Diabetes	☐ Hemophilia	☐ Seizures
☐ Anemia	☐ Difficulty Breathing	☐ Hepatitis A	☐ Shingles
☐ Angina Pectoris	☐ Drug Abuse	☐ Hepatitis B	☐ Sickle Cell Disease
☐ Arthritis	☐ Emphysema	☐ Hepatitis C	☐ Sinus Problems
☐ Artificial Bones	☐ Epilepsy	☐ High Blood Pressure	☐ Stroke
☐ Artificial Heart Valve	☐ Fainting Spells	☐ Kidney Problems	☐ Thyroid Problems
☐ Asthma	☐ Fever Blisters	☐ High Blood Pressure	☐ Tuberculosis
☐ Blood Transfusion	☐ Frequent Headaches	☐ Liver Disease	☐ Ulcers
☐ Bruise Easily	☐ Glaucoma	☐ Low Blood Pressure	☐ Venereal Disease
☐ Cancer	☐ HIV+ AIDS	☐ Mitral Valve Prolapse	☐ Yellow Jaundice
☐ Chemotherapy	☐ Hay Fever	☐ Pace Maker	☐ Other

Please explain any medical condition you checked above:

Do you require antibiotic pre-medication before dental treatment?

Are you allergic to any medications or substances? Check all that apply:

☐ Aspirin	☐ Erythromycin	☐ Metals	☐ Other
☐ Codeine	☐ Jewelry	☐ Penicillin	
☐ Dental Anesthetics	☐ Latex	☐ Tetracycline	

If “Other,” please explain:

Please list all current medications and what you’re taking them for:

Is there anything else you think the office should know that was not covered above?

I hereby acknowledge that the information given herein is correct to the best of my knowledge. I understand the information contained herein will be held in the strictest confidence and only be used in reference to my dental treatment and insurance filing.

Signature: _____

(If Patient is Under 18, Signature of Parent or Legal Guardian is Required)