Medical Alert:

Who may we thank for referring you? _____

Patient Information:

Miss, Mr., Mrs., Ms., Dr. _____

Home Ph _____ Work Ph _____ Date of Birth _____

Cell phone _____ Email _____

Address _____ P.O. Box _____

City _____ State _____ Zip _____

1st Insured's Name _____
Relationship to patient: Self, Parent, Spouse

Date of Birth _____ SS# _____

Employed By _____ City _____

Dental Ins. Co. _____ Gp # _____

2nd Insured's Name _____
Relationship to patient: Self, Parent, Spouse

Date of Birth _____ SS# _____

Employed By _____ City _____

Dental Ins. Co. _____ Gp # _____

Emergency Contact: Name _____ Phone (H) _____ (W) _____

Patient Medical History

Physician _____ Approximate date of last physical exam _____

Address _____ Office Phone _____

YES NO

☐ ☐ 1. Do you have now or have you had any major medical problem? List: _____

☐ ☐ 2. Are you now or have you recently been taking any drugs or medications? (Including over-the-counter drugs, "recreational" drugs, birth control pills, aspirin.) List: _____

☐ ☐ 3. Are you allergic or sensitive to any drugs or medicine? List: _____

☐ ☐ 4. Have you ever had an adverse reaction to local anesthetic?
If yes, describe reaction: _____

☐ ☐ 5. Do you have any difficulty with bleeding or healing from a cut, wound, or extraction?

☐ ☐ 6. Have you had any major operations? List: _____

☐ ☐ 7. Do you have any artificial joints or pins in any joints? _____

☐ ☐ 8. Have you had any serious accidents involving head injuries? List: _____

☐ ☐ 9. Have you ever been tested for HIV (AIDS virus)?
If yes, was test ☐ positive or ☐ negative?

☐ ☐ 10. Are you on a special diet?

11. To what extent do you use: a) tobacco _____ b) alcohol _____

12. Do you have or have you ever had any of the following: (✓ yes or no)

YES	NO		YES	NO		YES	NO	
☐	☐	Rheumatic Fever	☐	☐	Lung Problems (Asthma, TB, Pneumonia)	☐	☐	Convulsions (Seizures)
☐	☐	Mitral Valve Prolapse				☐	☐	Diabetes or Family History
☐	☐	Heart Murmur	☐	☐	Liver Problems (Hepatitis, Jaundice)	☐	☐	Fainting or Dizziness
☐	☐	Heart Disease	☐	☐	Stomach or Intestinal Problem (Ulcer)	☐	☐	Arthritis or Rheumatism
☐	☐	Heart Attack	☐	☐	Kidney Problems	☐	☐	Tumors or Growths
☐	☐	Hypertension (High Blood Pressure)	☐	☐	Asthma/Hay Fever	☐	☐	Sinus Problems
☐	☐	Stroke	☐	☐	Allergies to Food or Drugs	☐	☐	Skin Disease
☐	☐	Anemia or any Blood Disease	☐	☐	Nervous Disorders	☐	☐	Venereal Disease
			☐	☐	Latex allergy	☐	☐	Thyroid Problems

☐ ☐ 13. WOMEN: Are you pregnant? Approximate due date _____

☐ ☐ 14. CHILDREN: Does your child take daily fluoride supplements (chewable or liquid, Luride or poly-vi-fluor)?

☐ ☐ Do you have fluoridated water?

☐ ☐ Does your child suck his or her thumb or fingers?

Patient Dental History

☐ ☐ 1. Do you have a dental complaint? List: _____

2. When was your last dental visit? _____ Reason for visit: _____

3. When did you last have dental x-rays? _____

☐ ☐ 4. Do you have any lumps or sores in your mouth, head or neck?

☐ ☐ 5. Do your gums bleed?

☐ ☐ 6. Do you clench or grind your teeth?

☐ ☐ 7. Do you have pain in or near your ears?

☐ ☐ 8. Have you ever had orthodontic treatment?

☐ ☐ 9. Name of former dentist? _____

I certify that this information is correct and I consent for the patient named above to receive all dental treatment deemed necessary on this or any subsequent appointment. I understand the proposed treatment will be explained to me by the dental personnel. I accept responsibility for payment of all fees including any services or balances not covered by my insurance company.

Signature (patient, parent or guardian) _____ Date _____