PATIENT HEALTH HISTORY AND INFORMATION

Today's Date:_____

Name: _____ **Sex:** M F **Marital Status:** Single Married Divorced Other
Last First

Address: _____ **Home Phone:** _____
Street

_____
City Zip

Date of Birth: _____ **SSN:** _____ **Driver's License:** _____

Work Phone: _____ **Cell Phone:** _____ **Email:**_____

Employer: _____ **Occupation:**_____

Spouse's Name: _____ **SSN:** _____ **Date of Birth:**_____

Identification #: _____ **Phone:** _____ **Employer:** _____

Work Phone: _____

Emergency Contact: _____ **Phone:**_____
Who can we thank for referring you to our office: _____

MEDICAL/DENTAL HISTORY

Physician's Name: _____ **City/State:** _____ **Phone:**_____
When did you last consult physician? _____ **Reason:**_____
Have you been hospitalized within the past 5 years? ☐ **Yes** ☐ **No** **Reason:**_____
Name of former dentist: _____ **Date of last dental examination:**_____
Purpose of today's visit: ☐ **complete examination** ☐ **pain** ☐ **broken tooth** ☐ **other:**_____
Do you have, or did you have any of the following (Please check and describe fully under remarks)**:**

	YES	NO		YES	NO
1. Heart Disease	☐	☐	17. Ulcers	☐	☐
2. High Blood Pressure	☐	☐	18. Radiation Treatment	☐	☐
3. Blood disorder - Anemia	☐	☐	19. Liver or Kidney Disease	☐	☐
4. Rheumatic Fever	☐	☐	20. Hepatitis, Jaundice	☐	☐
5. Heart Murmur	☐	☐	21. AIDS/HIV+	☐	☐
6. Thyroid disease, hyperthyroidism…….	☐	☐	22. Tuberculosis, Emphysema	☐	☐
7. Diabetes	☐	☐	23. Allergies	☐	☐
8. Stroke	☐	☐	a. Penicillin	☐	☐
9. Epilepsy	☐	☐	b. Sulfa Drugs	☐	☐
10. Fainting	☐	☐	c. Local Anesthetic	☐	☐
11. Asthma	☐	☐	d. Latex	☐	☐
12. Psychiatric Treatment	☐	☐	24. Artificial joints	☐	☐
13 Arthritis	☐	☐	25. History of Bisphosphonate use	☐	☐
14. Tumor History	☐	☐	26. Pacemaker	☐	☐
15. Venereal Disease	☐	☐	27. Are you pregnant?	☐	☐
16. Sinus Trouble	☐	☐	28. Do you smoke or drink alcohol?	☐	☐
Have you had excessive bleeding requiring treatment?	☐	☐	- How often do you drink alcohol?		
Have you experienced any unfavorable reaction to previous dental treatment?				☐	☐
List any medications, drugs or pills you are taking……				☐	☐

Do you have any disease, condition or problem not listed above that you think the dentist should know about? _____

_____

Patient Signature:_____ Date:_____ Doctor Signature: _____ Date:_____

Patient Signature:_____ Date:_____ Doctor Signature: _____ Date:_____

Patient Signature:_____ Date:_____ Doctor Signature: _____ Date:_____