Name ______ Date of Birth ______ Sex ______
Home Address ______ Home Phone ______
Business Address ______ Bus. Phone ______
Email ______ Cell Phone ______
Person To Contact In Case of Emergency ______
Marital Status S M W D Soc. Sec. # ______

NEW PATIENT MEDICAL HISTORY

Physician ______ Office Phone ______ Date Of Last Physical Examination ______
Physician Address ______

		yes	no
1.	Are you under any medical treatment now?	☐	☐

2. Have you had any major operations or any head injuries? yes ☐ no ☐ If so, what? ______

3. Has a physician ever informed you that you had:

	yes	no		yes	no
AIDS or ARC	☐	☐	Thyroid Disorders?	☐	☐
Nervous System Disorder (seizures, epilepsy, cerebral palsy)	☐	☐	Respiratory Disorders (asthma, bronchitis)?	☐	☐
Rheumatic Fever?	☐	☐	Diabetes?	☐	☐
High Blood Pressure or Low Blood Pressure	☐	☐	Coronary Artery Disease (angina, heart attack)?	☐	☐
Glaucoma or any eye problems?	☐	☐	A Heart Ailment (heart murmur, valvular surgery)?	☐	☐
Any Blood Disease or Bleeding Disorders?	☐	☐	Arthritis, Rheumatism?	☐	☐
Herpes Virus?	☐	☐	Cancer?	☐	☐
Any Kidney Disease/Surgery?	☐	☐	Tuberculosis and/or Positive TB Test	☐	☐
Any Venereal Disease, Sexually Transmitted Disease?	☐	☐	Cerebrovascular Accident (stroke)?	☐	☐
Any Yellow Jaundice, Hepatitis, or Liver Disease?	☐	☐	Pneumonia?	☐	☐
Prosthetic Devices (artificial devices)?	☐	☐	Tumors or Growths?	☐	☐
Gastrointestinal Disorders?	☐	☐	Other?	☐	☐

		yes	no
4.	Are you presently taking any medications?	☐	☐

Anesthetics and other medications that may be necessary in your treatment may interact with prescriptions, over-the-counter drugs and medications, and illicit drugs. These interactions could be serious and fatal. You must inform the doctor of all drugs and medications you are now taking or have ever taken. You must also disclose if you are a recovering alcoholic or drug user. All information will be held in strict confidence and will not be disclosed without your prior approval.

		yes	no
5.	Do you have any allergies or have you ever had any allergic reactions (medications, hayfever, foods)?	☐	☐
6.	Have any wounds healed slowly or presented other complications?	☐	☐
7.	Women, are you pregnant? _____ Trimester _____ "Antibiotics decrease effectiveness of birth control pills!"	☐	☐
8.	Have you ever had any radiation therapy?	☐	☐
9.	Are you on a special diet at this time?	☐	☐

10. Do you smoke? yes ☐ no ☐ If so, how much daily? ______

11. Describe your general health at this time ______

NEW PATIENT DENTAL HISTORY

		yes	no
12.	Do you at the present time have any dental complaints?	☐	☐
13.	Do you have any pain in or near your ears?	☐	☐
14.	Have you ever had nitrous oxide (laughing gas) for dental work?	☐	☐
15.	Have you ever had local anesthesia for dental work?	☐	☐
	If so, did you have any reactions or allergic symptoms?	☐	☐
16.	Have you had any prolonged bleeding following a cut or surgery?	☐	☐
17.	Do your gums bleed spontaneously or when you brush your teeth?	☐	☐
18.	Have you ever had instructions on the care of your teeth and gums?	☐	☐

19. Is any part of your mouth sore to pressures or irritants (cold, sweets, etc.) yes ☐ no ☐ If so, where? ______

20. When was your last complete radiographic survey taken? ______ Where? ______

21. Why did you leave your last dental office?

______

22. What did you like best about any previous dentist?

______

23. What did you like least about any previous dentist?

______

24. What did you expect to have done today.

______

25. If you could wave a magic wand around your mouth and change it any way you want, what changes would you want to make?

______

Please sign here ______ Today's date ______

Your signature is also a file signature for dental insurance