original

Medical History Form

Patient Information

Last name:______________________________ First name:_______________________________ Age:________

Sex: M F DOB:___/___/_____ Social Security #:___________________ Driver's Lic #:_______________________

Address:____ Phone:______________________________

City:_________________ State:______________ Zip code:_______________

If patient is a minor, give Parent or Guardian's name:____

Responsible Party

Last name:________________________________ First name:_______________________________ Sex: M F

DOB:____/_____/_____ Relationship to patient:_________________________ Phone:___________________________

Employer:_____________________________ Occupation:___________________ Work Phone: ___________________

Reason for today's visit: (circle) Examination/Cleaning Pain/Swelling Broken tooth/filling

Date of last dental visit:____/_____/_____

Do you have any concerns about previous dental care or this dental visit?:____

Do your gums bleed? YES / NO Are your teeth loose? YES / NO

Have you have ever been told you have gum disease? YES / NO

Have you been told you have bad breath? YES / NO

Are your teeth sensitive to: Sweets Cold Heat Pressure

Have you ever had any pain in your jaw joints (clicking, popping)? YES / NO

Are you happy with your smile? YES / NO

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient signature:____Date:____________________________________

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient.

Print:____Relationship:______________________________________

Signature:____Date:___________________________________

Date	Changes/Comments	Signature of Patient and Dentist
____/____/____	_____________________________	________________________________
____/____/____	_____________________________	________________________________