MEDICAL HISTORY RECORD

(If history is on a minor, all employment questions pertain to parents.)

Date_____

Single ☐ Widow ☐
Married ☐ Divorced ☐
Male ☐ Female ☐

Name of Patient_____ Age _____ Birth Date_____ Weight _____

Address_____ City _____ State _____ Zip_____

S.S. #☐☐☐-☐☐-☐☐☐☐ Telephone Number_____ Business Phone _____

Employed by _____ Occupation_____

Husband, Wife,_____ or Parent's Name (if you are under 18)_____

Employed by _____ City_____ Occupation_____

Dentist's Name_____ City _____

Physician's Name_____ M.D.☐ D.O.☐ City _____

Who referred you to this office?_____

Name and Phone number of nearest relative not in same household_____

Circle any of the following which you have had or have at present, and when:

Heart Pacemaker	Skin Rashes or Hives	Anemia or Hemophelia	Cortisone Medicine	Epilepsy
High Blood Pressure	Kidney Trouble	Bruise Easily	Pain in Jaw Joints	AIDS/HIV
Heart disease	Diabetes	Shortness of Breath	Fainting or Dizzy Spells	Cold Sores
Heart Attack	Sickle Cell Disease	Artificial Joint	Alcoholism	Seizures
Heart Murmur or MVP	Hepatitis	Emphysema	Drug Addiction	Psychiatric Treatment
Artificial Heart Valve	Blood Transfusion	Tuberculosis (TB)	Cancer or Tumor	Prolonged Bleeding
Rheumatic Fever	Thyroid Disease	Asthma	Stroke	Sinus

1. Have you, within the past two years, been under the care of a physician? Yes ☐ No ☐
   What for?_____ When? _____

2. Other serious illnesses? Explain _____ Yes ☐ No ☐

3. Have you ever had a reaction (allergy) to a drug, medicine, or latex?_____ Yes ☐ No ☐
   To what?_____

4. Have you taken any drugs or medicine during the last six months besides aspirin or Anacin?___Yes ☐ No ☐
   What medication?_____ When? _____

5. If female, are you now pregnant?_____ Due Date?_____

6. At the present time do you have a cold, cough or stuffed nose?_____ Yes ☐ No ☐

7. Do you have Dental Insurance?_____ Insurance Company, Name_____ ID#_____

Secondary Insurance?_____ ID#_____ SS#_____ BirthDate_____

If you have dental insurance, we will be happy to assist you in processing your claims for benefits to which you are entitled. You must realize that your insurance company has an obligation to you and not to the dentist. This office has no contractual arrangement with insurance carriers or unions. I accept full financial responsibility for the treatment performed by this office. I agree to pay all costs of collection including reasonable attorney fees and court costs. Payment to the doctor is expected at the time services are rendered, unless other arrangements are made.

_____ Signature

_____ Relation to Patient, if Minor