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