NAME_____ DATE OF BIRTH_____
Month / Day / Year

MEDICAL: *(If you brought a written list of your medications, please provide to the receptionist.)*

1. When was your last medical examination? _____/_____ (Mo./Yr.)
   Physician's Name: _____ If necessary, may we contact? Yes No
   Specialist's Name: _____ If necessary, may we contact? Yes No
2. Have you been under a physician's care during the past two years? ..... Yes No
3. Within the last 3 years, have you been hospitalized or had surgery? ..... Yes No
   If yes, please give reasons and dates: _____
4. Have you ever been instructed to take ANY medications or precautions before dental appointments? Yes No
   If yes, please explain: _____
5. Are you taking ANY drugs, medications, or treatments at this time? ..... Yes No
   Prescribed:_____
   Over the counter:_____
   Vitamins/herbals:_____
6. Are you allergic to (itching, swelling, rash), or have you ever experienced an unusual reaction to:

___ Dental anesthesia ___ Latex ___ Penicillin (of related drugs) ___ Tetracycline ___ Clindamycin (Cleocin)
___ Keflex (Cephalexin) ___ Iodine ___ Aspirin/Ibuprofen(Advil, Motrin) ___ Sulfa drugs ___ Tranquilizers (Valium)
___ Erythromycin ___ Codeine ___ NSAID (Celebrex, Vioxx, Anaprox) ___ Other _____

7. Check any of the following which you have had or have at present:

☐ Congenital heart defects	☐ High/Low blood pressure	☐ Ulcers	☐ Osteoporosis
☐ Angina pectoris/chest pain	☐ Anemia	☐ Thyroid disease	☐ Bisphosphonates
☐ Atherosclerosis	☐ Hemophilia/blood disorder	☐ Radiation/Cobalt treatment	☐ Pain in jaw joints
☐ Congestive heart failure	☐ Excessive bleeding	☐ Chemotherapy	☐ Compromised Immunity
☐ Coronary artery disease	☐ Diabetes	☐ Asthma	(Lupus,HIV,AIDS)
☐ Heart surgery	☐ Hypoglycemia	☐ Hay fever/Allergies/Hives	☐ STD
☐ Heart failure/attack	☐ Sickle cell disease	☐ Sinus problems	☐ Cold Sores
☐ Rheumatic fever	☐ Bruise easily	☐ Emphysema	☐ Poor wound healing/MRSA
☐ Scarlet fever	☐ Blood transfusion	☐ Chronic/whooping cough	☐ Epilepsy/Seizures
☐ Heart murmur	☐ Artificial joint/joint surgery	☐ Tuberculosis (TB)	☐ Fainting/Dizzy spells
☐ Heart valve damage/prolapse	☐ Hepatitis A / B / C	☐ Arthritis	☐ Mental health issues
☐ Artificial heart valve	☐ Liver disease/Jaundice	☐ Rheumatism	☐ Psychiatric treatment
☐ Pacemaker	☐ Organ transplant	☐ Cortisone Medicine	☐ Nervousness
☐ Stroke/CVA	☐ Kidney trouble	☐ Glaucoma	☐ Drug addiction

8. Do you smoke or use chewing tobacco? ..... Yes No
9. When walking/taking stairs, do you ever stop due to chest pain, shortness of breath or tiredness? Yes No
10. Do your ankles swell during the day? ..... Yes No
11. Do you use **more** than two pillows to sleep? ..... Yes No
12. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
13. Do you ever wake up from sleep short of breath? ..... Yes No
14. Are you on a special diet? ..... Yes No
15. Has your medical doctor ever said you have a cancer or tumor? ..... Yes No
16. Do you have any disease, condition, or problem not listed? ..... Yes No
17. Women:Are you pregnant now? Yes No Due date_____ Are you currently nursing? ..... Yes No
    Are you taking birth control pills? Yes No Do you anticipate becoming pregnant? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or prescription changes, I will inform the doctor of dentistry at the next appointment without fail.

Date _____ Signature of Patient, Parent of Guardian_____

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition
_____	_____
_____	_____
_____	_____
_____	_____

Name_____Preferred Name: _____
Last Name First Name Initial

Gender Identity: ☐ M ☐ F ☐ Other Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Single ☐ Married ☐ Widowed

Age _____ Birth Date _____ Soc.Sec. #_____

Address_____

City_____State_____Zip_____

Email:_____ Telephone: _____

Patient Employed by_____Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you? _____

Notify in case of emergency _____Home Phone _____Work Phone_____

Primary Insurance *(Leave blank if no insurance)*

Person Responsible for Account_____
Last Name First Name Initial

Relation to Patient_____ Birth Date_____ Soc. Sec. # _____

Address (if different from patient)_____Phone_____

City_____ State_____ Zip_____

Person Responsible Employed by_____Occupation_____

Business Address_____Business Phone_____

Insurance Company_____Phone_____

Plan #_____Group #_____Subscriber #_____

Secondary Insurance

Subscriber Name_____ Relation to Patient _____Birth Date_____
Last Name First Name Initial

Address (if different from patient)_____ Soc. Sec. #_____

City_____ State_____ Zip _____ Phone _____

Subscriber Employed by_____Business Phone_____

Insurance Company_____Phone_____

Plan #_____ Group #_____ Subscriber #_____