Medical History for New Patient

Last Name: First Name: Birthdate: SSN: ______

Email Address: ______ Phone/Cell Phone: ______

Mailing Address: ______ City/State: ______

Emergency Contact ______ Phone ______ Relationship ______

List all medications that you are now taking:

______ ______ ______

______ ______ ______

______ ______ ______

______ ______ ______

______ ______ ______

Do you take a premedication prior to dental treatment? ______

Are you allergic to any of the following?

Y	Y
☐ Anesthetic	☐ Penicillin/Amoxicillin
☐ Aspirin	☐ Sulfa
☐ Codeine	☐ Latex
☐ Other: ______	

Do you have any of the following medical conditions?

Y	Y	Y
☐ Asthma	☐ Kidney Disease	☐ Frequent Headaches
☐ Bleeding Problems	☐ Liver Disease	☐ Osteoporosis/Osteopenia
☐ Cancer	☐ Pregnancy	☐ Radiation Treatment
☐ Diabetes Type I or II	☐ Psychiatric Treatment	☐ Hepatitis
☐ Heart Murmur	☐ Sinus Trouble	☐ Arthritis
☐ Heart Trouble	☐ Stroke	☐ Dementia
☐ High Blood Pressure	☐ Ulcers	
☐ Joint Replacement	☐ Rheumatic Fever	

List any other conditions: ______

Any other significant medical conditions? ______

Recent surgery: ______

Tobacco use? If so, what kind and how much? ______

Reason for today's visit ______ Are you in pain? ______

New Patients Only:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ______

Do you have BiteWing x-rays that are less than 1 year old? ______

Name of former dentist ______ City/State ______

Date of last cleaning and exam ______

How did you hear about us? ______

Date:

Patient Signature: ______