MEDICAL HISTORY: tell us about you...

PATIENT INFORMATION

p a t i e n t

Name Miss. / Mrs. / Mr. ______ (First) ______ (Middle) ______ (Last) ______ Date Of Bitrh ______

Address ______ City ______ State ______ Zip ______

Parent/Guardian/Spouse ______

Address ______ City ______ State ______ Zip ______

Social Security Number ______ Employer ______

Home Phone ______ Office Phone ______

Family Physician ______ Reffered to this office by ______

Are you covered by Dental Insurance ______ If so, please answer the following: ______ Date of Birth of Insured Person: ______

Insured Person ______ Employer of Insured Person ______

Policy # or Group # ______ SS # of Insured Person ______

Name and address of Insurance Company ______

DENTAL INFORMATION

d e n t a l

Do your gums bleed when you brush or floss?		Yes	No
Have your gums receded		Yes	No
Have you noticed any loose teeth?		Yes	No
Have you had any periodontal (gum) surgery?		Yes	No
Are your teeth sensitive to:	Hot?	Yes	No
	Cold?	Yes	No
	Sweets?	Yes	No
	Biting Pressure?	Yes	No

Would you say that you have had a minimal, moderate, or major amount of previous dental treatment?

Would you guess that you need a minimal, moderate, or major amount of dental treatment now?

Have you ever had any permanent teeth extracted? Yes No

If so, when? ______

When was your last dental exam? ______

Are you satisfied with your smile (color, shape, spaces, etc.) Yes No

Why did you leave your previous dentist? ______

HEALTH QUESTIONS

h e a l t h

Have you ever had:

Condition	Yes	No
Asthma	Yes	No
Allergies or Hives	Yes	No
Tuberculosis	Yes	No
Stroke	Yes	No
Heart Disease or Attack	Yes	No
Angina Pectoris	Yes	No
High Blood Pressure	Yes	No
Pacemaker	Yes	No
Heart Murmur	Yes	No
Rheumatic Fever	Yes	No
Joint Replacement	Yes	No
Blood Transfusion	Yes	No
Emphysema	Yes	No
Hepatitis	Yes	No
HIV Infection or AIDS	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No
Kidney or Bladder Disease	Yes	No
Diabetes	Yes	No
Epilepsy or Seizures	Yes	No
Fainting or Dizzy Spells	Yes	No
Anemia	Yes	No
Glaucoma	Yes	No
Abnormal Bleeding	Yes	No
Thyroid Disease	Yes	No
Sickle Cell Disease	Yes	No
Stomach or Intestinal Ulcers	Yes	No
Malignancies (Cancer)	Yes	No
Chemo or Radiation	Yes	No
Women: Are you pregnant?	Yes	No
Have you ever taken any diet pills?	Yes	No

Are you being treated by a physician now? Yes No If yes, for what reason(s)? ______________________

Are you taking any medications at the present time? Yes No If yes, which medications? ______________________

Are you sensitive or allergic to any medications? Yes No List name and reaction: ______________________

Have you ever been hospitalized? Yes No List reasons and dates: ______________________

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform Dr. Tarver at the next appointment without fail. Payment is due at the time of service unless prior arrangements have been made. All accounts 60 days past due will be charged 1 1/2% interest per month.

Date ______________________ Signature of Patient, Parent or Guardian ______________________