lee
FAMILY **DENTISTRY** P.C.

MEDICAL AND PERSONAL HISTORY

Name _____
(Last) *(First)* *(MI)*

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell _____ OK to text Yes / No

Sex (M / F) *(Circle)* Marital Status (S / M / D / W) *(Circle)* Age____ Birth Date_____ Social Sec. # _____

Email Address_____ Name of Responsible Party _____

If patient is under age 18: Father's Name _____ Mother's Name _____

Insurance Yes / No Insurance Company Name _____ ID #_____

Employer Name_____ Occupation_____

Referred by *(Circle)*: Patient of Practice | Brochure | Dentist/Doctor Referral | Internet
Employee of Office | Location | Yellow Pages | Employer
Insurance Company | Other _____

Family/friends treated in practice_____

In Case of Emergency, notify_____ Phone #_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Heart Condition	Anemia or Hemophilia	Skin Rash or Hives	Cortisone Medicine
Heart Attack or Stroke	Bruise Easily	Kidney Trouble	Glaucoma
Heart Murmur	Shortness of Breath	Diabetes	Arthritis
Chest Pains (Angina)	Swelling of Ankles	Sickle Cell Disease	Pain in Jaw Joints
Heart Surgery	Artificial Joint	Liver Disease	Artificial Heart Valve
Fainting or Dizzy Spells	Lung Disease	Hepatitis	Alcoholism
Heart Pacemaker	Emphysema	Sinus Trouble	Drug Addiction
High Blood Pressure	Tuberculosis (T.B.)	Blood Transfusion	Cancer or Tumor
Rheumatic Fever	Asthma or Hay Fever	Thyroid Disease	Radiation Therapy
Chemotherapy	HIV Positive/AIDS	Venereal Disease	Genital Herpes
Cold Sores	Epilepsy	Seizures	Psychiatric Treatment

If you circled any conditions, diseases, or problems above, please explain: _____

Do you have any conditions, disease, or problems not listed above? If yes, please explain. _____

Continue on reverse side

Are you presently taking any over-the-counter or prescription medicine, drug, or substance? Yes / No
If yes, please list drug, dose, and frequency _____

_____

_____

_____

Are you allergic to any medication, drug, or substance? Yes / No If yes, please list: _____

_____

_____

_____

Are you now, or have you been under the care of a medical doctor during the last two years? . . . . . Yes / No
Have you ever been hospitalized or had surgery? . . . . . Yes / No
Have you ever had a reaction to local anesthetic? . . . . . Yes / No
Have you ever had prolonged or unusual bleeding? . . . . . Yes / No
Have you ever had complications or illness following dental treatment? . . . . . Yes / No
Have you ever had an injury to your face or jaw? . . . . . Yes / No
Do you smoke or use smokeless tobacco? . . . . . Yes / No
Are you nervous or concerned about having dental work done? . . . . . Yes / No
Are you having any pain or discomfort at this time? . . . . . Yes / No

What is your present health? Good ____ Fair ____ Poor ____

Comments: _____

_____

_____

_____

_____

Women:

Are you pregnant? Due date _____ . . . . . Yes / No
Are you taking birth control pills? . . . . . Yes / No
Do you anticipate becoming pregnant? . . . . . Yes / No

Dental Treatment desired: *(Circle)*

Checkup	Replace Missing Teeth	Cavities Restored	Crowns/Caps
Cleaning	Teeth Removed	Dentures	Implants
Cosmetic Dentistry	Consultation		

Other _____

Signature of Patient, Parent, or Guardian _____ Date _____

Doctor's Notes: _____

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