CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Last Name_____**First**_____ **Middle**_____

Street Address_____**City**_____**State & Zip**_____

Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

E-Mail:_____**SS#**_____**DOB: _____Marital Status___ Sex:**_____

MEDICAL HISTORY

Have you been hospitalized within the past 12 months? _____ Reason: _____

Check any of the following that you have had or suspect to have:

_____Arthritis
_____Rheumatic Fever
_____Heart Trouble
_____Heart Murmur
_____High/Low Blood Pressure
_____Chest Pain
_____Stroke
_____Asthma
_____Sinus
_____Hepatitis or Jaundice
_____Liver Disease
_____Cancer/Tumors
_____Tuberculosis
_____Diabetes
_____Kidney/Bladder
_____Anemia
_____Venereal Disease
_____Blood Transfusion
_____Prolonged Bleeding
_____Fainting Tendency
_____Epilepsy
_____Thyroid Disease
_____Glaucoma
_____Radiation Treatment
_____Mental Illness
_____Hip/Knee Replacement

List all Medications:

Are you allergic to any medications? _____ If yes explain_____

Women: Are you pregnant? _____ If yes how far along_____

Who may we thank for referring you? _____

DENTAL INSURANCE

Insurance Company: _____
Subscriber Name: _____ Relationship _____
SS# _____ DOB: _____
Employer: _____

The above information is true to the best of my knowledge.

SIGNATURE: _____ DATE_____