

Medical/Dental History

Patient Name		Date of Birth	
Address	City	Postal Code	Gender Male Female
Phone	Mobile Phone	Preferred method of contact? Phone SMS Email	

Adult Patient		Child Patient	
Occupation	Marital Status M S D W	Mother's name	
Employer	Phone (work)	Mother's employer	Mother's phone (work)

Insurance Company		Father's name	
Plan Number	ID Number	Father's employer	Father's phone (work)
How did you find about us?		Person responsible for account	

1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what?

Physician's name Physician's phone

2. Have you taken any medication drugs (prescription, recreational or supplements) now or during the past two years? Yes No
 If yes, please list the name and dosage

3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
 If yes, please list

4. Have you been hospitalized in the past five years? Yes No

5. Do you smoke or chew tobacco? Yes No

6. Do you have / wear snore guard, CPAP Machine or nightguard? Yes No

7. Indicate which of the following you have had, or presently have

Heart (Surgery, Disease, Attack)	Chest Pain	Congenital Heart Disease
Heart Murmur	High Blood Pressure	Artificial Heart Valve
Mitral Valve Prolapse	Heart Pacemaker	Rheumatic Fever
Arthritis / Rheumatism	Cortisone Medicine	Swollen Ankles
Stroke	Diet (Special / Restricted)	Artificial Joints (hip, knee etc.)
Kidney Trouble	Latex Sensitivity	Stomach Ulcers
Diabetes	Thyroid Problems	Glaucoma
Emphysema	Chronic Cough	Tuberculosis
Asthma	Hay Fever	Allergies or Hives
Sinus Trouble	Radiation Therapy	Chemotherapy
Tumors	Sleep Apnea	Hepatitis
Liver Disease	Yellow Jaundice	Venereal Disease
A.I.D.S.	H.I.V. Positive	Cold Sores / Fever Blisters
Blood Transfusion	Hemophilia	Sickle Cell Disease
Bruise Easily	Neurological Disorders	Epilepsy or Seizures
Fainting or Dizzy Spells	Nervous / Anxious	Psychiatric / Psychological Care
Have you ever taken penicillin?	Excessive bleeding	Issues with Tonsils or Adenoids?
Jaw Surgery	Have you been advised to take antibiotics prior to dental treatment?	

8. Have you had or do you have any medical condition not listed? Yes No
If yes, please list

9. Have you had orthodontic treatments Yes No
If yes, when? Length of treatment

10. Women

Are you pregnant?

Yes No

Are you nursing?

Yes No

Are you taking birth control pills?

Yes No

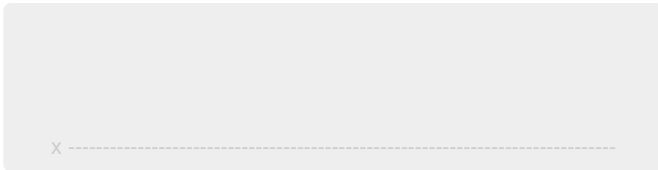
Are you using a hormone releasing IUD?

Yes No

First & Last Name

Email Address

Signature

A light gray rectangular box intended for a signature. It contains a horizontal dashed line with a small 'x' character at the beginning, indicating where to sign.