2911 A.W. Grimes Ste 600, Pflugerville TX, 78660
1-877-631-7022

MEDICAL HISTORY FORM

Date

____

Patient Information:

Patient's Name:

____

Last First Middle Initial

Address:

____

City State Zip Code

Email Address: ____________________ SSN: ______ - ____ - _____ Date of Birth: ______/ _____ / ____

Age: _____

Sex: □ M □F

Home No: _________________ **Cell No:** ___________________ **Alt. No**: ____________________

Parent/Guardian Insurance Information:

Relationship to Patient: __________________ □ SELF

Name:

____

Last First Middle Initial

SSN: ______ - _____- _________ Insurance No.: ______________ Driver License No.: _____________________

Date of Birth: ______ / ____ / _______ Insurance Telephone No.: ____________ Group No.:
____

Employer: ________________________ Address: ____

Home No: ________________________ Cell No: __________________________ Work No:__________________

Name and Number of nearest relative not living with you: ____

How did you hear about us?

Please mark below:

□ Yellow Pages □ Friend / Relative □ Flyers / Mail □ Internet

□ Sign □ THMP-Medicaid □ Health Fairs / Screenings □ Other (Specify)

□ Employee □ Insurance / Employer □ TV Ad-Which Station? _________ ___________________________

□ BillBoard Reason for today's dental visit: ______________________

Date of last dental visit: ______________________

Have you ever had an experience in a dental office that you would like to tell us about? □ Yes □ No

Please explain if yes: ____

Are you nervous about dental treatment? □ Yes □ No □ Do your gums bleed, feel tender or irritated? Yes □ No □
Are you unhappy with the appearance of your teeth? Yes □ No

Are your teeth sensitive? □ Yes □ No Do you have discolored
teeth that bother you? □ Yes □ No

If yes, to what? □ Sweets □ Hot □ Cold □ Pressure Are you now seeing a physician? □ Yes □ No The name & telephone number of your physician(s)____________________________________ If so, what is the condition being treated?
____

Are you taking any medications? □ Yes □ No If yes, please list:
____

Have you or are you currently taking Aspirin? □ Yes □ No If female, are you or do you suspect to be pregnant? □ Yes □ No Months:
____

Have you or are you currently taking oral Bisphosphonates? □ Actonel □ Boniva □ Fosamax □ Skelif □ Didrone □ Other
____

Have you had any joint replacements? □ Yes □ No If yes, when?
____

Is there anything else we should know about your health that was not covered in this form? □ Yes □ No

If yes, Please explain:
____ ________

Please mark any of the following which you have had or have at present:

□ NONE

□ Heart Disease □ Anemia □ Nervousness □ HIV + AIDS

□ Heart Murmur □ Kidney Trouble □ Thyroid Disease □ Hepatitis

□ High Blood Pressure □ Bone Loss □ Chemo: (Cancer, Leukemia) □ Hemophilia

□ Blood Disease □ Epilepsy or Seizures □ Arthritis □ Sickle Cell Disease

□ Rheumatic Fever □ Ulcers □ Rheumatism □ Bruise Easily

□ Venereal Disease □ Emphysema □ Cortisone Medicine □ Pain in Jaw
Joint

□ Heart Pacemaker □ Tuberculosis □ Joint Replacement □ Diabetes

□ Asthma □ Scarlet Fever □ Hay Fever □
Glaucoma

Please mark any of the following medical allergies:

□ NONE

□ Local Anesthetics □ Penicillin □ Codeine or other narcotics □
Fen-Phen

□ Aspirin □ Other antibiotic: □ Barbiturates or sedatives □

Other: ___________________

□ Iodine □ Sulfa Drugs □ Latex □

Other: ___________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change, I will inform my dentist at the next appointment.

____ **Signature of Patient/Parent/Guardian**