A COUNTRY DENTIST

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Last Name_____ First Name_____ Date_____

Address_____ Zip Code_____

Home Phone ( )_____ Cell ( )_____ Work ( )_____

E-mail address_____ Can we text message you? _____

What is the best way to contact you? _____

Date of Birth_____ Social Security #_____ Employer_____

In case of emergency contact_____
(Name) (Phone #) (Relationship)

MEDICAL HISTORY

Are you now or have you recently been under a physician's care? Yes _____ No _____

Reason _____

Physician's Name _____ Phone # _____

Check any of the following medical conditions you may have had:

_____Anemia	_____Epilepsy/Seizures	_____Lung Disease
_____Arthritis	_____Fainting Tendency	_____Mental Disorders
_____Artificial Heart Valve/Stent	_____Glaucoma	_____Metal Allergy
_____Artificial Joints	_____Heart Disease/Surgery	_____Osteoporosis
_____Asthma/Hay Fever	_____Headache/Migraine	_____Shortness of Breath
_____Blood Disease/Prolonged Bleeding	_____Hepatitis or Jaundice	_____Sinus Trouble
_____Blood Transfusion	_____High/Low Blood Pressure	_____Stroke
_____Blood Thinner	_____HIV or AIDS	_____Thyroid Disease
_____Cancer or Tumor	_____Jaw Pain	_____Tobacco use
_____Chest Pain	_____Kidney/Bladder Trouble	(smoke/chew)
_____Diabetes	_____Liver Disease	_____Venereal Disease

What is your normal alcohol intake? _____

Are you taking any medication or supplements? _____Yes _____No

If yes, please list _____

Are you allergic to anything? _____Yes _____No
If yes please list _____

Are you pregnant? _____Yes _____No If yes how many months? _____ Are you breast feeding? _____Yes ____No

_____ Yes, you may use my testimonial, photos, video and name to let other patients know about my great experience with your office for educational purposes.

Patient's Signature _____
(parent if patient is a minor)

By signing here, I am verifying that all information on this form is accurate and current.