MEDICAL HISTORY: tell us about you...

PATIENT INFORMATION

Name Miss. / Mrs. / Mr. ________ (First) (Middle) (Last) Date Of Bitrh________

Address________ City________ State________ Zip________

Parent/Guardian/Spouse________

Address________ City________ State________ Zip________

Social Security Number________ Employer________

Home Phone________ Office Phone________

Family Physician________ Reffered to this office by________

Are you covered by Dental Insurance________ If so, please answer the following:________ Date of Birth of Insured Person:________

Insured Person________ Employer of Insured Person________

Policy # or Group # ________ SS # of Insured Person________

Name and address of Insurance Company________

DENTAL INFORMATION

Do your gums bleed when you brush or floss?		Yes	No
Have your gums receded		Yes	No
Have you noticed any loose teeth?		Yes	No
Have you had any periodontal (gum) surgery?		Yes	No
Are your teeth sensitive to:	Hot?	Yes	No
	Cold?	Yes	No
	Sweets?	Yes	No
	Biting Pressure?	Yes	No

Would you say that you have had a minimal, moderate, or major amount of previous dental treatment?

Would you guess that you need a minimal, moderate, or major amount of dental treatment now?

Have you ever had any permanent teeth extracted? Yes No

If so, when?________

When was your last dental exam?________

Are you satisfied with your smile (color, shape, spaces, etc.) Yes No

Why did you leave your previous dentist?________

HEALTH QUESTIONS

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Have you ever had:

Condition			Condition		
Asthma	Yes	No	Osteoporosis	Yes	No
Allergies or Hives	Yes	No	Arthritis	Yes	No
Tuberculosis	Yes	No	Kidney or Bladder Disease	Yes	No
Stroke	Yes	No	Diabetes	Yes	No
Heart Disease or Attack	Yes	No	Epilepsy or Seizures	Yes	No
Angina Pectoris	Yes	No	Fainting or Dizzy Spells	Yes	No
High Blood Pressure	Yes	No	Anemia	Yes	No
Pacemaker	Yes	No	Glaucoma	Yes	No
Heart Murmur	Yes	No	Abnormal Bleeding	Yes	No
Rheumatic Fever	Yes	No	Thyroid Disease	Yes	No
Joint Replacement	Yes	No	Sickle Cell Disease	Yes	No
Blood Transfusion	Yes	No	Stomach or Intestinal Ulcers	Yes	No
Emphysema	Yes	No	Malignancies (Cancer)	Yes	No
Hepatitis	Yes	No	Chemo or Radiation	Yes	No
HIV Infection or AIDS	Yes	No	Women: Are you pregnant?	Yes	No
			Have you ever taken any diet pills?	Yes	No

Are you being treated by a physician now? Yes No If yes, for what reason(s)? ____________________

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Are you taking any medications at the present time? Yes No If yes, which medications? ____________________

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Are you sensitive or allergic to any medications? Yes No List name and reaction: ____________________

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Have you ever been hospitalized? Yes No List reasons and dates: ____________________

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To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform Dr. Tarver at the next appointment without fail. Payment is due at the time of service unless prior arrangements have been made. All accounts 60 days past due will be charged 1 1/2% interest per month.

____________________ ____________________

Date Signature of Patient, Parent or Guardian