

**DENTAL RECORD**

**Personal**

Nick Name \_\_\_\_\_ Name \_\_\_\_\_ (First, Middle Initial, Last!)

Date of Birth: \_\_\_\_\_ 19\_\_\_\_, Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: Male Female

Social Security # \_\_\_\_\_ Marital Status: S M D W Occupation: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

**General**

What is your reason for coming to this office today? \_\_\_\_\_ Person who sent you to this office: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ City: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Family Physician: \_\_\_\_\_ City: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Medical History**

Have you ever had or have? (Please answer both columns)

YES	NO	
		Anemia or blood disease
		Rheumatic fever
		Heart murmur
		Heart condition or surgery (valve, pacemaker, bypass)
		High blood pressure
		Organ transplant surgery
		Arthritis
		Temporomandibular joint (TMJ) disorder
		Artificial joint surgery
		Lung disease (asthma, TB)
		Kidney disease
		Liver disease (hepatitis, jaundice)
		Diabetes
		Do you smoke?
		Do you have a cold?
		For females: are you pregnant?
		For females: are you taking birth control pills?
		Do you feel you are in good general health?
		Are you taking any medications, drugs, or pills? If so, list them

YES	NO	
		Prolonged bleeding following surgery or injury
		Thyroid or other hormonal problems
		Dizziness, convulsions, or seizures
		Skin disease
		Sexually transmitted disease
		HIV-positive test for AIDS
		Radiation treatment of head and neck
		Chemotherapy
		Cortisone or steroid therapy
		Psychiatric treatment
		Alcohol or drug abuse
		Cancer or tumor
		Other diseases not listed
		Are you allergic to:
		Latex
		Household bleach
		Are you allergic to or had ill effects from any foods, medications, or drugs? If so, list them
		Have you had any surgery (operations) in the last 5 years? If so, list them

I certify that the above information is correct to the best of my knowledge. **RETURN TO FRONT DESK WHEN COMPLETED**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

If minor, signature of parent or guardian: \_\_\_\_\_ Relation to patient: \_\_\_\_\_