MEDICAL HISTORY FORM

DREAMWORKS DENTAL & ORTHODONTICS

Patient Information:

Last Name: _____ First: _____ M.I. _____

Sex: [ ]M [ ]F Date of Birth: _____ Age: _____ Social Security: _____

Responsible Party Information:

Last Name: _____ First: _____ M.I. _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Driver's License: _____ Date of Birth: _____ Social Security: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship to patient: _____ Employer: _____ Occupation: _____

Name/Address/Ph# of nearest relative that DOES NOT live with you, and whom we may call in case of an emergency:

_____

Reason for today's visit: _____

Are you seeing a physician? [ ]YES [ ]NO If yes, what is the condition being treated? _____

Name and address of your physician: _____

What medications are you taking now? _____

IF FEMALE, are you pregnant? [ ]YES [ ]NO If yes, how long? _____

Any history of complications with dental treatment? [ ]YES [ ]NO If yes, please describe_____

Are you currently experiencing any oral/dental sensitivity or pain? [ ]YES [ ]NO

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

[ ] Heart Trouble/Disease	[ ] Artificial Joints	[ ] Hay Fever	[ ] Epilepsy/Seizure	[ ] Pain in Jaws
[ ] Heart Mumur	[ ] Hypo/Hyperglycemia	[ ] Sinus Trouble	[ ] Thyroid Disease	[ ] ADD/ADHD
[ ] Angina/Chest Pain	[ ] Diabetes	[ ] Asthma	[ ] Parathyroid Disease	[ ] Depression
[ ] Heart Attack/Failure	[ ] Anemia	[ ] Breathing Problems	[ ] Kidney Problems	[ ] Psychiatric Disorder
[ ] Stroke	[ ] Sickle Cell Disease/Trait	[ ] Shortness of Breath	[ ] Renal Dialysis	[ ] Alcohol Use/Abuse
[ ] Congenital Heart Disorder	[ ] Blood Disease	[ ] Snoring/Sleep Apnea	[ ] Yellow Jaundice	[ ] Drug Addiction/Abuse
[ ] Mitral Valve Prolapse	[ ] Hemophilia/Bleeding Problems	[ ] Frequent Cough	[ ] Liver Disease	[ ] Recent Weight Loss
[ ] Heart Surgery	[ ] Excessive Bleeding	[ ] Emphysema	[ ] Hepatitis A, B, or C	[ ] Herpes/Cold Sores
[ ] Artificial Heart Valve	[ ] Bruise Easily	[ ] Tuberculosis	[ ] AIDS	[ ] Canker Sores
[ ] Heart Pace Maker	[ ] Recent Blood Transfusion	[ ]Lung Disease	[ ] HIV Positive	[ ] Venereal Disease
[ ] Irregular Heart Beat	[ ] Leukemia	[ ]Stomach/Intestinal Disease	[ ] Arthritis/Gout	[ ] Cortisone/Steroid Use
[ ] Rheumatic/Scarlet Fever	[ ] S welling of Limbs	[ ]GI Ulcers	[ ] Rheumatism	[ ] Tobacco Use
[ ] High Blood Pressure	[ ] Excessive Thirst	[ ] Frequent Diarrhea	[ ] Cancer	[ ] Other
[ ] Low Blood Pressure			[ ] Radiation/Chemotheraphy	

Mark any of the following medications/substances you are allergic to:

[ ] Local Anesthetics	[ ] Penicillin/other antibiotics	[ ] Barbiturates, sedatives, or sleeping pills	[ ] Other _____
[ ] Aspirin	[ ] Codeine/other narcotics	[ ] Acrylic	
[ ] Iodine	[ ] Sulfa Drugs	[ ] Latex Rubber	

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

_____ _____

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE **TODAY'S DATE**

FOR OFFICE USE ONLY:
Medical History Updated:

DOCTOR	**DATE**	**DOCTOR**	**DATE**	**DOCTOR**	**DATE**