FAWCETT CENTER FOR DENTISTRY, P.A.
THE ART of DENTISTRY

Medical History

Patient Name ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________
Are you on a special diet? ◯ Yes ◯ No ______________
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ______________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes	Cortisone Medicine	◯ Yes	Hemophilia	◯ Yes	Renal Dialysis	◯ Yes
Alzheimer's Disease	◯ Yes	Diabetes	◯ Yes	Hepatitis A	◯ Yes	Rheumatic Fever	◯ Yes
Anaphylaxis	◯ Yes	Drug Addiction	◯ Yes	Hepatitis B or C	◯ Yes	Rheumatism	◯ Yes
Anemia	◯ Yes	Easily Winded	◯ Yes	Herpes	◯ Yes	Scarlet Fever	◯ Yes
Angina	◯ Yes	Emphysema	◯ Yes	High Blood Pressure	◯ Yes	Shingles	◯ Yes
Arthritis/Gout	◯ Yes	Epilepsy or Seizures	◯ Yes	Hives or Rash	◯ Yes	Sickle Cell Disease	◯ Yes
Artificial Heart Valve	◯ Yes	Excessive Bleeding	◯ Yes	Hypoglycemia	◯ Yes	Sinus Trouble	◯ Yes
Artificial Joint	◯ Yes	Excessive Thirst	◯ Yes	Irregular Heartbeat	◯ Yes	Spina Bifida	◯ Yes
Asthma	◯ Yes	Fainting Spells/Dizziness	◯ Yes	Kidney Problems	◯ Yes	Stomach/Intestinal Disease	◯ Yes
Blood Disease	◯ Yes	Frequent Cough	◯ Yes	Leukemia	◯ Yes	Stroke	◯ Yes
Blood Transfusion	◯ Yes	Frequent Diarrhea	◯ Yes	Liver Disease	◯ Yes	Swelling of Limbs	◯ Yes
Breathing Problem	◯ Yes	Frequent Headaches	◯ Yes	Low Blood Pressure	◯ Yes	Thyroid Disease	◯ Yes
Bruise Easily	◯ Yes	Genital Herpes	◯ Yes	Lung Disease	◯ Yes	Tonsillitis	◯ Yes
Cancer	◯ Yes	Glaucoma	◯ Yes	Mitral Valve Prolapse	◯ Yes	Tuberculosis	◯ Yes
Chemotherapy	◯ Yes	Hay Fever	◯ Yes	Pain in Jaw Joints	◯ Yes	Tumors or Growths	◯ Yes
Chest Pains	◯ Yes	Heart Attack/Failure	◯ Yes	Parathyroid Disease	◯ Yes	Ulcers	◯ Yes
Cold Sores/Fever Blisters	◯ Yes	Heart Murmur	◯ Yes	Psychiatric Care	◯ Yes	Venereal Disease	◯ Yes
Congenital Heart Disorder	◯ Yes	Heart Pace Maker	◯ Yes	Radiation Treatments	◯ Yes	Yellow Jaundice	◯ Yes
Convulsions	Yes	Heart Trouble/Disease	◯ Yes	Recent Weight Loss	◯ Yes		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

UPDATES: ______________________________

FAWCETT CENTER FOR DENTISTRY, P.A.
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1 PATIENT

Today's Date ______________________

Why have you come to the dentist today? ______________________

____

____

____

Any special concerns? ______________________

____

____

____

3 DENTAL INSURANCE

Insurance Co. Name ______________________

Policy/Group # ______________________

Insurance Co. Address ______________________

Insurance Co. Phone # ______________________

Policyholder ______________________

Relationship ______________________

Insured's Birth Date _____ / _____ / _____

Insured's Member ID ______________________

Insured's Employer ______________________

Employer Tel. # ______________________

4 IN EVENT OF EMERGENCY

Is there someone who lives near you that we should contact?

Name ______________________

Relationship ______________________

Hm # ______________________

Cell # ______________________

Wk # ______________________

2 ABOUT YOU

Last Name ______________________

First Name ______________________

Middle ______________________

E-mail ______________________

SS # ______________________

DL # ______________________

Home Address ______________________
(no P. O. Box)

City ____________ State ______ Zip ________

Hm # ______________________

Cell # ______________________

Wk # ______________________

❑ Male ❑ Female Birth Date _____ / _____ / _____

Whom may we thank for referring you? ______________________

____

Previous Dentist ______________________

Employer ______________________

Address ______________________

City ____________ State ______ Zip ________

Tel. # ____________ Occupation ____________

SPOUSE INFORMATION

Name ______________________

Employer ______________________

Birth Date _____ / _____ / _____

SS # ______________________

Hm # ______________________

Cell # ______________________

Wk # ______________________