



north richardson
DENTISTRY ASSOCIATES

610 Old Campbell Rd #116 Richardson, TX 75080 - Tel: 972-426-2288

MEDICAL HISTORY FORM

Date: \_\_\_\_\_

Patient Information:

Patient's Name: Last First Middle Initial
Address: City State Zip Code
SSN: Date of Birth Age: Sex: M / F
Cell No: Email:

Insurance Subscriber/ Information:

Relationship to Patient: \_\_\_\_\_

Name: Last First Middle Initial
SSN: Insurance No.: Driver License No.:
Date of Birth: Insurance Telephone No.: Group No.
Employer: Address:
Home No: Cell No: Work No:
Name and Number of nearest relative not living with you:

How did you hear about us? Please mark below:

- Office Sign, West Lovers Team Member, Friend / Relative, Insurance, Flyers / Mail, Health Fairs, Google, Social Media, Yelp, Other

Reason for today's dental visit: Date of last dental visit:
Have you ever had an experience in a dental office that you would like to tell us about? Yes / No
Please explain if yes:
Are you nervous about dental treatment? Do your gums bleed, feel tender or irritated? Yes Are you unhappy with appearance of your teeth? Yes / No
Are your teeth sensitive: Do you have discolored teeth that bother you?
Hot / Cold/ Sweets / Pressure Yes / No
Are you now seeing a physician? Yes / No The name & telephone number of your physician(s)
If so, what is the condition being treated?
What medications are you taking?
Tobacco Use: Yes / No
Are you taking any oral Bisphosphonates? Yes / No Type:
Do you take blood thinners? Yes / No Type:
Have you had any joint replacements? Yes / No
If female, are you pregnant? Yes / No Months:
Is there anything that we should know about that is not covered in the form? Yes / No Type:

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

- Heart Disease, Heart Murmur, High Blood Pressure, Blood Disease, Rheumatic Fever, Venereal Disease, Heart Pacemaker, Tuberculosis, Diabetes, Scarlet Fever, Anemia, Kidney Trouble, Epilepsy or Seizures, Ulcers, Emphysema, Pain in Jaw Joints, Asthma, Hay Fever, Nervousness, Thyroid Disease, Chemo: (Cancer, Leukemia), Arthritis, Rheumatism, NONE, Cortisone Medicine, Glaucoma, HIV + AIDS, Hepatitis, Hemophilia, Sickle Cell Disease, Bruise Easily

Please mark any of the following medications you are allergic to:

- Local Anesthetics, Aspirin, Iodine, Penicillin or other antibiotic, Sulfu Drugs, Codeine or other narcotics, Barbiturates, sedatives, or sleeping pills, NONE, Other:

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

Signature of Patient/Parent/Guardian

Medical History Update:
Dr. Date Dr. Date Dr. Date