



MALLARD CREEK
DENTAL

Date _____

MEDICAL HISTORY FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Initial: _____

Address: _____

City State Zip

Email Address: _____

Date of Birth: ____/____/____ Age: _____ Sex: ___M ___F

SSN: ____-____-____ Driver's License #: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Employer Phone: _____

Name and number of nearest relative not living with you: _____

How did you hear about us? _____ Referral (Name of referral _____)

____ Advertisement/Sign _____ Insurance/Employer _____ Internet/Facebook

PARENT/GUARDIAN INFORMATION: (Complete if patient is under 18 years of age)

Relationship to Patient: _____

Guardian Name: _____

Address (if different from above): _____

Address City State Zip

Email Address: _____ SSN: ____-____-____

Employer: _____ Employer Phone: _____

Date of Birth: ____/____/____ Driver's License #: _____

Home Phone: _____ Cell: _____ Work: _____

INSURANCE INFORMATION:

Insurance Company: _____ Insurance Address: _____

Insurance Group #: _____ Insurance ID #: _____ Insurance Phone: _____

DENTAL CONCERNS / HISTORY

Reason for today's 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? ___ Yes ___ No

Do your gums bleed, feel tender or irritated? ___ Yes ___ No

Are you unhappy with the appearance of your teeth? ___ Yes ___ No

Do you have discolored teeth that bother you? ___ Yes ___ No

Sensitive teeth? ___ Yes ___ No - If yes, to what? ___ Sweets ___ Hot ___ Cold ___ Pressure

MEDICAL HISTORY

Are you now seeing a physician? ___ Yes ___ No Condition being treated: _____

Physician: _____ Physician phone#: _____

Current Medications: _____

Have you or are you currently taking aspirin? ___ Yes ___ No

If female, are you or do you suspect to be pregnant? ___ Yes ___ No Months: _____

Have you or are you currently taking oral Bisphosphates? _____ Actonel _____ Boniva _____ Fosamax
_____ Skelif _____ Didrone ___ Other _____

Have you had any joint replacements? ___ Yes ___ No If yes, when? _____

Is there anything else about your health we should be aware of? ___ Yes ___ No

Please explain if yes: _____

Please mark any of the following, which you have had or have at present: _____ NONE

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervousness | <input type="checkbox"/> HIV + AIDS |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Chemo (Cancer Leukemia) | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Pain in Jaw/Joint |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Glaucoma |

Please mark any of the following medical allergies: _____ NONE

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> Fen-Phen |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other antibiotic | <input type="checkbox"/> Barbiturates or sedatives | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Idodine | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Latex | <input type="checkbox"/> 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

For office use only:
Medical History Update:

Date

Date

Date