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

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

Please mark any of the following medical allergies: _____ NONE

Local anesthetics	Penicillin	Codeine or other narcotics	Fen-Phen
Aspirin	Other antibiotic	Barbiturates or sedatives	Other _____
Idodine	Sulfa Drugs	Latex	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