Medical history

Today's date: _____

Patient name: _____
Last name Name Initial

Social Security number: _____ Sex: m F Date of birth: _____ Age: _____

If the patient is a minor, please provide the name of the father or guardian: _____

INFORMACION DE LA PERSONA RESPONSABLE:

Name: _____ Civil status: _____
Last name Name Initial

Address: _____ City: _____ Status: _____ Code: _____

# of driver's license: _____ Date of birth: _____ relationship to the patient: _____

#'s de Telefono: Casa (_____)_____ Cell (_____)_____ Trabajo (_____)_____

Email: _____

Employer: _____ Occupation: _____

Name/Address/Telephone of the closest relative who does not live with you: _____

How do I hear about us?PLEASE THEM BELOW:

Yellow Pages	Television	Radio	Sign	Health/School Fair
Friend/relative	Newspaper	Cupon by mail	Employer	Announcement of the billboard
Employee	Other: _____			

Reason for your visit today: _____

Date of the last dental visit: _____ Reason: _____

Have you ever had an experience in a dentist office that wants to tell us?Yes no yes, please explain to us:

_____

Are you apprehensive to dental treatment?BUT	Are your heat sensitive/cold/pressure teeth?BUT
Does gums bleed or the seven irritated and sensitive?BUT	Do you have discolored teeth that bother you?BUT
Are you being treated by a doctor?BUT	Is he happy with the appearance of his teeth?BUT

Yes, for what medical condition?_____

Name/address/telephone of your doctor: _____

Drug list: _____

If she is a woman, is she pregnant?Yes no yes, how long?_____

Mark anyone who has had or has at this time:

Anemia	Cardiac pacemakers	Ulcers	Thyroid disease	Glaucoma
Diabetes	High pressure	EMPLEME	Cancer, leukemia	Jaw pain
Scarlet fever	Tuberculosis	Arthritis	Blood disease	Breath
Rheumatic fever	Kidney problems	Hay fever	Cortisone medicine	Hemophilia
Asthma	Rheumatism	Bruises easily	Heart disease	HIV (AIDS)
Venereal disease	Epilepsy	Nervousness	Falciform cell disease	Hepatitis

Mark any of the following medicines to which you are allergic:

Local anesthesia	Penicillin or other antibiotic	Sulfa drugs
Aspirin	Codeina or other narocotic	Barbituric sedatives or sleeping pills
Iodine	Other _____	

To my best knowledge all the above answers are true and correct.If at any time I have
Some change in my health or in the medicines that I take, I will inform my dentist in the next appointment.

_X_____ _____
Patient signing/father/Guardian Date

_____ _____
Doctor's signature Date