

## PATIENT'S GENERAL HISTORY

The following information is necessary to aid us in the evaluation and treatment of you or your child.

Name: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 Sex: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Financially responsible person: \_\_\_\_\_  
 Billing address: \_\_\_\_\_  
 Mother's name: \_\_\_\_\_  
 Father's name: \_\_\_\_\_  
 Dental Health insurance: \_\_\_\_\_  
 Social security number: \_\_\_\_\_  
 How did you hear about our office: \_\_\_\_\_  
 Physician or pediatrician: \_\_\_\_\_  
 General dentist: \_\_\_\_\_

## MEDICAL HISTORY (please circle all that apply)

Is \_\_\_\_\_ in good health? Yes No  
 Does he/she have regular medical examinations? Yes No  
 Is he/she taking any medications at the present time? Yes No  
 If yes, please specify: \_\_\_\_\_

Has he/she ever had an unfavorable reaction to a drug or medicine? Yes No  
 Has he/she been hospitalized in the last year? Yes No  
 Is he/she taking fluoride tablets or drops? Yes No

Does \_\_\_\_\_ have a history of:

Heart disorder	Yes	No
Rheumatic fever	Yes	No
Diabetes	Yes	No
Kidney disorder	Yes	No
Epilepsy	Yes	No
Bleeding disorder	Yes	No
Allergies	Yes	No
Liver disorder	Yes	No
Asthma	Yes	No
Sexually transmitted disease	Yes	No
Mental health problems	Yes	No
Does he/she have poor coordination Or problems with hearing, vision or speech?	Yes	No