Medical History Form, Value Dental, 110 N Hwy 175, Seagoville. (972) 200 3399

PATIENT INFORMATION Date (Month, Date, Year) __ __ / __ __ / __ __ __ __

Patient's Last Name ________________________________ First ______________________________ Middle _____________

Social Security Number __ __ __ - __ __ - __ __ __ __ Sex ☐ M ☐ F Date of Birth __ __ / __ __ / __ __ Age____________

If Patient is a Minor, give Parent's or Guardian's Name ____

RESPONSIBLE PARTY INFORMATION

Last Name _________________________First ________________________Middle ______________ Marital Status ________

Address____ City__________________ State___________ Zip__ __ __ __ __

Driver's License No.__ __ __ __ __ __ __ __ Home Phone (______)_______________Work Phone (______) _________________

Date of Birth __ __ /__ __ / __ __ __ __ Relationship to Patient ____

Employer_______________________________Occupation _________________________ Number of Years Employed_______

Name of Emergency Contact_________________________ Address of Emergency Contact ______________________________

____Phone (______)_______________

HOW DID YOU HEAR ABOUT US? PLEASE CHECK BELOW

☐ Billboard ☐ Mail Coupon ☐ Yellow Pages ☐ Employee ______________________________

☐ Valpak ☐ Health Fair ☐ Friend/Relative ☐ Newspaper/Radio (Specify) _______________

☐ Google ☐ MSN ☐ Yahoo ☐ Website/Other __________________________

MARK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

☐ Heart Disease ☐ Heart Pacemaker ☐ Ulcers ☐ Thyroid Disease ☐ Glaucoma

☐ High Blood Pressure ☐ Diabetes ☐ Pain in Jaw Joints ☐ Chemo (Cancer, Leukemia) ☐ Emphysema

☐ Blood Disease ☐ Scarlet Fever ☐ Tuberculosis ☐ Arthritis ☐ HIV+

☐ Rheumatic Fever ☐ Anemia ☐ Asthma ☐ Rheumatism ☐ Hepatitis

☐ Heart Murmur ☐ Kidney Trouble ☐ Hay Fever ☐ Cortisone Medicine ☐ Hemophilia

☐ Venereal Disease ☐ Epilepsy or Seizures ☐ Nervousness ☐ Sickle Cell Disease ☐ Bruise Easily

If so, what is the condition being treated? ____

The Name and Address of my Physician (s) is ____

What medications are you taking now? ____

If female, are you pregnant? ☐ Yes ☐ No If Yes, how long? ____

MARK ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO

☐ Local Anesthetics ☐ Sulfa Drugs ☐ Iodine ☐ Penicillin or other Antibiotics ☐ Aspirin

☐ Codeine & Narcotics ☐ Barbiturates, Sedatives, or Sleeping Pills ☐ Other__________________________________

DENTAL HISTORY

1. Are you concerned about or experiencing any of the following dental problems? (Please tick all that apply)

☐ Sensitivity to Hot or Cold ☐ Food Trapping between your Teeth ☐ Clicking/Pain in the Jaw Joints

☐ Staining of your Teeth ☐ Discolored Fillings ☐ Roughness of Existing Fillings

☐ Bleeding Gums ☐ Bad Breath ☐ Sensitivity while Eating

☐ Head, Neck Ache ☐ Grinding or Clenching of Teeth ☐ Silver (Amalgam) Filling

☐ Existing crowns, bridges, dentures ☐ Ability to eat ☐ Gaps between your teeth

☐ Teeth Cleaning (Brushing, Flossing) ☐ Your smile ☐ Discoloration of your teeth

☐ Crooked Teeth ☐ Missing Teeth ☐ Other (Specify) ____________

Reason for today's dental visit?____

Date of last dental's visit? __ __ / __ __ / __ __ Reason____

2. Have you ever had or require the following for dental treatment?

☐ Gas (Nitrous Oxide, Laughing Gas) ☐ Intravenous Sedation ☐ General Anesthesia

3. Have you ever had an experience in a dental office, which you would like to tell us about?

☐ No ☐ Yes (please explain) ____

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

Signature of Patient _________________________ Signature of Parent/Guardian______________________________________

FOR OFFICE USE ONLY,

DOCTOR ____ Date (Month, Date, Year) __ __ / __ __ / __ __ __ __