Medical History – Patient Information

Date: _____

PURE DENTAL STUDIO

Patient's Name:_____
Last First Middle Initial

Address: _____
Address City State Zip Code

Email Address:_____@_____ SSN: _____ - _____ -_____

Date of Birth:_____ / _____ / _____ Age: ___ Sex: o M o F DL/ID #:_____

Home No.: _____Cell No.: _____ Alt. No.: _____

Parent/Guardian Information: (required if patient is under 18)

Relationship to the Patient: _____ o Self

Name:_____
Last First Middle Initial

Dental Insurance Information: Policy Holders Name(First/Last): _____ Relationship to Patient: _____

Date of Birth:_____ / _____ / _____ Employer: _____

Dental Insurance Company: _____ Subscriber No.: _____

Dental Ins. Phone No.: _____ Group No.: _____

SSN #: _____

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

How did you hear about us? Please mark below:

o Online	oTV	o Referring Doctor	o Friend Family
o Flyers / Mail	o Community Event	o Walking/Driving By	o Office Employee (Specify)
o Sign	o Health Fairs /Screenings	o Medicaid/TMHP/CHIP	_____
o Billboard o Radio		o Insurance/Employer	_____

Reason for today's dental visit:_____ Date of last dental visit: _____

Have you ever had an experience in a dental office that you would like to tell us about? o Yes o No

Please explain if yes: _____

Are you nervous about dental treatment? o Yes o No
Do your gums bleed, feel tender or irritated? o Yes o No
Are you unhappy with appearance of your teeth? o Yes o No
Are your teeth sensitive? o Yes o No
If yes, to what? o Sweet o Hot o Cold o Pressure _____
Do you have discolored teeth that bother you? o Yes o No
If female, are you or do you suspect to be pregnant? o Si o No Months?_____

832.604.7737
PUREDENTALSTUDIO1@GMAIL.COM
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Please mark any of the following which you have had or have at present: o NONE

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

Have you had any joint replacements? o Yes o No

If yes, when? _____

Are you now seeing a physician? o Yes o No

The name & telephone number of your physician(s) _____

If so, what is the condition being treated? _____

Please mark any of the following medical allergies: o NONE

o Local Anesthetics	o Aspirin	o Latex
o Penicillin	o Barbiturates or sedatives	o Other: _____
o Codeine or other narcotics	o Iodine	
o Fen-Phen	o Sulfa Drugs	

Are you taking any medications? o Yes o No

If yes, please list: _____

Have you or are you currently taking Aspirin? o Yes o No

Have you or are you currently taking oral Bisphosphates?

o Actonel o Boniva o Fosamax o Skelif o Didrone o Other _____

Is there anything else we should know about your health that was not covered on this form?

o Yes o No If yes, Please explain: _____

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

**********Medical History Update**********

_____ _____ _____

Dr. Date Dr. Date Dr. Date