

Studio City Dental Group

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ID No. _____

Name: _____ Sex: M F Birthdate: _____ Age: _____

Today's Date: _____ How long since last dental visit? _____ For: _____

Why did you make this appointment? Routine Checkup Pain Other: _____

How did you learn of our office? Personal Referral By: _____ Other: _____

Home Address _____ City _____ Zip _____

Home Telephone () _____ Occupation _____

E-mail address _____ Marital Status _____

Employer _____ Address _____

City _____ Zip _____ Soc. Sec. No. _____

Business Phone () _____ Ext. _____ Do you have dental Insurance? Yes No

Insurance Plan _____ Group No. _____ Driver's Lic. _____

If married, Spouse's Name _____ Employer _____

Employer's Address _____ City _____

Zip _____ Business Phone () _____ Spouse Dent. Ins. Yes No

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In general, how is your health? _____ Who is your physician? _____

Address _____ City _____ Zip _____ Telephone () _____

Are you presently being treated by a physician? If Yes, for what condition? _____

_____ Name of treating physician _____

Have you ever had a serious illness? If yes, please detail _____

Have you ever been hospitalized in the past 2 years? If yes, please explain _____

If presently taken medication, please give name of medicine and what you take it for _____

Do you have any health problems we should be aware of? If yes, please describe _____

Do you have any allergies? Latex other, please describe _____

Have you ever had an unusual reaction to a dental anesthetic? Yes No if yes, please describe

Do you presently have or have you ever had any of the following conditions?

	Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Coughing	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Type_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV-Positive	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Drug/ Alcohol Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Use of Phen-Phen	<input type="checkbox"/>	<input type="checkbox"/>	Severe Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>

Please check appropriate box if anyone with whom you have been intimate has had:

Intravenous Drug Use AIDS HIV-Positive Hepatitis Venereal Disease

(Women) Are you pregnant, or is there a possibility that you might be? Yes No If yes, _____ months

We realize that many patients are anxious in a dental office. If you have had a particularly unpleasant, or especially favorable experiences during dental treatment, please describe them _____

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 my medicines change, I will inform the dentist at the next appointment. My Signature below is my consent for treatment.

Signature of patient, parent, or guardian

Date

If you have made any changes in your medical history, please initial those changes and sign below

Signature of patient, parent, or guardian

Date

To be filled in by dentist: Med. Hx. Reviewed _____ by _____ Soft Tissues: WNL ____ Yes No
