2460 Mission Street San Francisco, California 94110 - Tel: 415-849-9991

MEDICAL HISTORY FORM **Date: _______________**

Patient Information:

Patient's Name: ____
Last First Middle Initial

Address: ____
City State Zip Code

SSN: _______________________________ Date of Birth___________ Age:_________ Sex: **M / F**

Cell No:__________________________ **Email**: ______________________________

Insurance Subscriber/ Information: *Relationship to Patient*: ______________________

Name: ____
Last First Middle Initial

SSN: _______________________ Insurance No.: _______________ Driver License No.:_________________________

Date of Birth: _________________ Insurance Telephone No.: _________________ Group No. _________________

Employer: ____________________ Address: ______________________________________

Home No: ____________________ Cell No:_______________ Work No:________________________

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

How did you hear about us? Please mark below:

- □ Office Sign
- □ West Lovers Team Member
- □ Friend / Relative
- □ Insurance
- □ Flyers / Mail
- □ Health Fairs
- □ Google
- □ Social Media
- □ Yelp
- □ Other _________________

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? **Yes / No**

Please explain if yes: ____

Are you nervous about dental treatment? **Yes / No**

Do your gums bleed, feel tender or irritated? **Yes / No**

Are you unhappy with appearance of your teeth? **Yes / No**

Are your teeth sensitive: **Hot / Cold/ Sweets / Pressure**

Do you have discolored teeth that bother you? **Yes / No**

Are you now seeing a physician? **Yes / No** The name & telephone number of your physician(s) ______________________________

If so, what is the condition being treated? ______________________________________

What medications are you taking? ______________________________________

Tobacco Use: **Yes / No**

Are you taking any oral Bisphosphonates? **Yes / No** Type:____________________________________

Do you take blood thinners? **Yes / No** Type:____________________________________

Have you had any joint replacements? **Yes / No**

If female, are you pregnant? **Yes / No** Months: _________

Is there anything that we should know about that is not covered in the form? **Yes / No** Type:______________________________

Please mark any of the following which you have had or have at present:

- □ Heart Disease
- □ Heart Murmur
- □ High Blood Pressure
- □ Blood Disease
- □ Rheumatic Fever
- □ Venereal Disease
- □ Heart Pacemaker
- □ Tuberculosis
- □ Diabetes
- □ Scarlet Fever
- □ Anemia
- □ Kidney Trouble
- □ Epilepsy or Seizures
- □ Ulcers
- □ Emphysema
- □ Pain in Jaw Joints
- □ Asthma
- □ Hay Fever
- □ Nervousness
- □ Thyroid Disease
- □ Chemo: (Cancer, Leukemia)
- □ Arthritis
- □ Rheumatism
- □ **NONE**
- □ Cortisone Medicine
- □ Glaucoma
- □ HIV + AIDS
- □ Hepatitis
- □ Hemophilia
- □ Sickle Cell Disease
- □ Bruise Easily

Please mark any of the following medications you are allergic to:

- □ Local Anesthetics
- □ Aspirin
- □ Iodine
- □ Penicillin or other antibiotic
- □ Sulfa Drugs
- □ Codeine or other narcotics
- □ Barbiturates, sedatives, or sleeping pills
- □ **NONE**
- □Other:_____________

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**