HISTORY CARD

Personal Information

Date: ______________________

Name ______________________ Birth Date: ______________________

Address: ______________________

City: ______________________ Postal Code: ______________________

Phones: Res.: ______________________ Bus.: ______________________

Occupation: ______________________

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Sex ________ Wt. ________ Ht. ________ Marital Status: ______________________

Whom may we thank for referring you? ______________ ______________________

Physician's Name: ______________________ Phone: ______________________

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Date of last medical examination: ______________________

Dental Insurance Information

Type of Dental Plan: ______________________

Group Number: ______________________

Certificate or I.D. Number: ______________________

Subscriber's Name:

____

Subscriber's S.I.N.: ______________________

Subscribers's D.O.B.: ______________________

Medical History

	Yes	No
1. Has there been any change in your general health in the past year?	☐	☐
2. Are you under the care of a physician now?	☐	☐
3. Have you ever had a serious illness or have you ever been hospitalized?	☐	☐
4. Have you had a medical examination in the last year?	☐	☐
5. Are you taking any medicines or drugs at the present time?	☐	☐

6. Have you ever had or been treated for: **(please circle)**

Heart trouble or stroke — Rheumatic fever or
Rheumatic heart disease — Abnormal blood pressure
Thyroid disease — Stomach or intestinal ulcer
Jaundice, hepatitis or liver disease — Diabetes
Epilepsy — Gall bladder — Tuberculosis
Lung disease — Arthritis or rheumatism — Cancer
Anemia — Blood disorders — Kidney disease
Mental or nervous disease — Venereal disease
Gastrointestinal disease — Injury to face or jaw
Growth or tumor

	Yes	No
7. Have you ever have or been treated for HIV or Aids?	☐	☐
8. Do you ever have asthma, hay fever, hives or skin rash?	☐	☐
9. Are you allergic to anything?	☐	☐
10. Have you ever had a local anaesthetic (freezing)?	☐	☐
11. Did it cause problems?	☐	☐
12. Have you been warned against taking any medicine or drug or local anaesthetic (freezing)?	☐	☐
13. Have you ever experienced fainting, shortness of breath, chest pains or swollen ankles?	☐	☐
14. Has your weight changed recently?	☐	☐
15. Are you on a diet?	☐	☐
16. Do you bruise easily or bleed abnormally?	☐	☐
17. Do you heal easily and normally?	☐	☐
18. Have you ever had x-ray, radiation or cobalt therapy?	☐	☐
19. Is there anything that the dentist should know regarding your medical history that has not been mentioned?	☐	☐

20. Are you pregnant? Yes ☐ No ☐
if yes. in what stage or term of pregnancy ______________________

Dental History

	Yes	No
1. Have you ever been under regular care by a dentist?	☐	☐
2. Have you ever had any teeth extracted?	☐	☐
3. Where there any complications involved?	☐	☐
4. Do any of your teeth ache?	☐	☐
5. Do your gums bleed when you brush?	☐	☐
6. Do your gums feel tender or swollen?	☐	☐
7. Do you have any loose teeth?	☐	☐
8. Does food catch between your teeth?	☐	☐
9. Do you floss your teeth?	☐	☐
10. What is your present dental problem?	☐	☐

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Consent for Operations

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature______________________ Date ________

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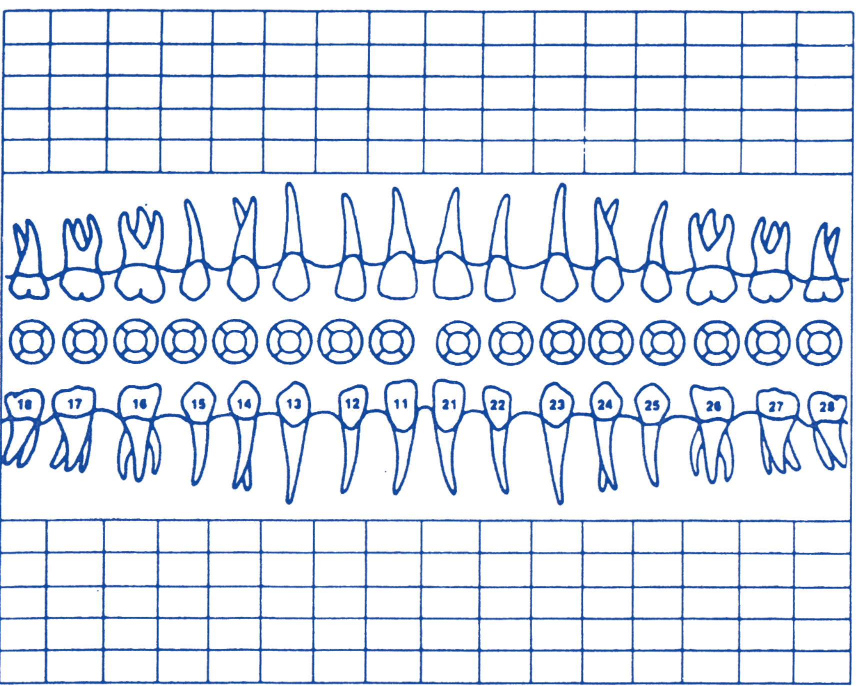

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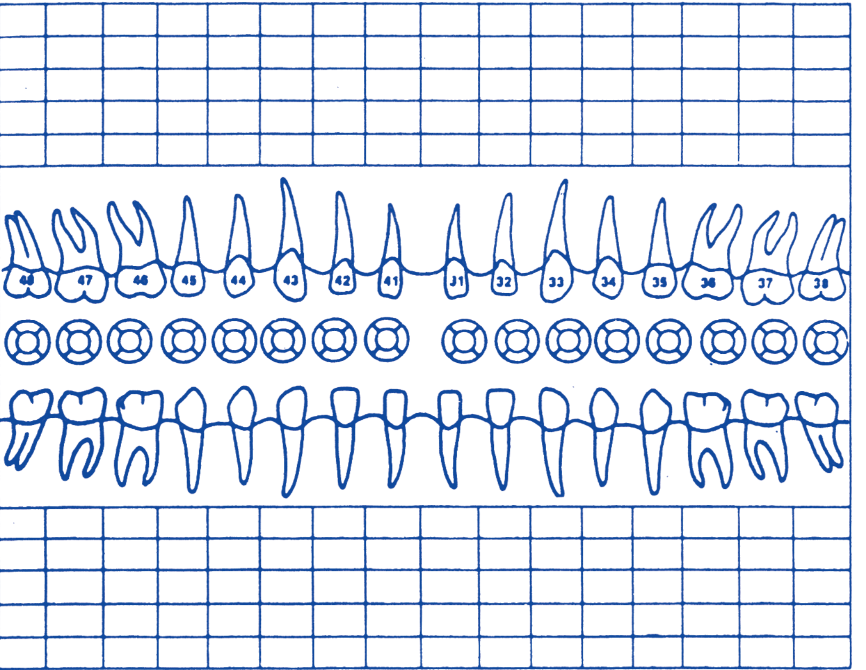

NAME MR. MRS. MISS ____________________ DATE OF BIRTH __ __ __
D M Y

Initial Exam

Date ____________________

TMJ —

LYMPH —

SOFT TISSUES —

O/J —

O/B —

CLASS —

CROSSBITE — slide —

R/S prematurities —

L/S

R/S

L/S

balancing contacts

Vitality Tests

Treatment Plan

Date ____________________