RADIANT DENTAL

Westchase – Spring Branch

MEDICAL HISTORY FORM

Patient Information:

Last Name: _____ First: _____ M.I._____
Sex: [ ] M [ ] F Date of Birth: _____ Age: _____ Social Security: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____

Do you have Insurance?[ ] Yes [ ] NO Ins:_____ Employer:_____ ID # _____

Responsible Party Information (if under 18yrs or a dependent on Insurance)

Last Name: _____ First: _____ M.I. _____ Marital Status: _____
Address: _____ City: _____State: _____ Zip Code: _____
Driver's License: _____ Date of Birth: _____ Social Security: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Relationship to patient: _____ Employer: _____Occupation: _____
Emergency Contact: _____Phone #: _____ Primary Language Spoken: _____

Reason for today's visit: _____
Are you seeing a physician? [ ]***Yes*** [ ] ***No*** If yes, what is the condition being treated? _____
Please list all current Medication (including Over the Counter Medication): _____
_____
Physician Name: _____ Phone #: _____

FEMALE, ARE YOU PREGNANT? [ ] *YES* [ ] *NO* IF YES, HOW LONG? _____

Are You Taking Birth Control? [ ] ***Yes*** *[ ]* ***No*** *Are You Nursing [ ]* ***Yes*** *[ ]* ***No***

Note if you are a woman some antibiotics may alter the effectiveness of birth control pills, please consult your Ob/Gyn

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

Are your teeth sensitive to hot, cold, sweets or pressure? [ ] ***Yes*** *[ ]* ***No***

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

[ ] Heart Trouble/Disease	[ ] Blood Disease	[ ] Frequent Cough	[ ] Frequent Diarrhea	[ ] Parathyroid Disease
[ ] Heart Murmur	[ ] Alcohol Use/Abuse	[ ] Hay Fever	[ ] Diabetes	[ ] Arthritis/Gout
[ ] Irregular Heart Beat	[ ] Depression	[ ] Sinus Trouble	[ ] Excessive Thirst	[ ] Rheumatism
[ ] Angina/Chest Pain	[ ] Bruise Easily	[ ] Asthma	[ ] Hypoglycemia	[ ] Pain in Jaw Joints
[ ] Heart Attack/Failure	[ ] Anemia	[ ] Fever Blisters	[ ] Liver Disease	[ ] Cortisone Medicine
[ ]Congenital Heart Disorder*	[ ] Excessive Bleeding	[ ] ADD/ADHD	[ ] Hepatitis A & C (Infectious)	[ ] Artificial Joints*
[ ] Mitral Valve Prolapse*	[ ] Sickle Cell Disease	[ ] Emphysema	[ ] Hepatitis B (Serum)	[ ] Venereal Disease
[ ] Scarlet Fever	[ ] Hemophilia (Bleeding Problems)	[ ] Tuberculosis	[ ] Hepatitis C	[ ] AIDS*
[ ] Rheumatic Fever	[ ] Leukemia	[ ] Cancer	[ ] Stroke	[ ] HIV Positive
[ ] Artificial Heart Valve*	[ ] Recent Blood Transfusion	[ ] Radiation Therapy	[ ] Seizure	[ ] Herpes (Cold Sore)
[ ] Heart Pace Maker*	[ ] Swelling of Limbs	[ ] Chemotherapy	[ ] Yellow Jaundice	[ ] Drug Addiction/Use
[ ] Heart Surgery*	[ ] Lung Disease	[ ]Stomach/Intestinal Disease	[ ] Kidney Problems	[ ] Genital Herpes
[ ] High Blood Pressure	[ ] Breathing Problems	[ ] Ulcers	[ ] Renal Dialysis	[ ] Snoring/Sleep Apnea
[ ] Low Blood Pressure	[ ] Shortness of Breath	[ ] Recent Weight Loss	[ ] Thyroid Disease	**[ ] NONE of the ABOVE**

[ ] Other Not Listed:

Mark any of the following medications/substances you are allergic to:

[ ] Local Anesthetics	[ ] Penicillin/other antibiotics	[ ] Barbiturates, sedatives, or sleeping pills	[ ] Other _____
[ ] Aspirin	[ ] Codeine/other narcotics	[ ] Acrylic, Metal	
[ ] Iodine	[ ] Sulfa Drugs	[ ] Latex Rubber	**[ ] NONE**

* If Allergic: Reactions:

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

_____ _____
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

FOR OFFICE USE ONLY: _____ _____
DOCTOR **DATE**