

Miracle Dental Associates, LLC Medical History

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ City/State: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

List all medications or drugs you are now taking:

None

List all medications or drugs you are allergic to:

None

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen:

None

Tobacco use? If so, what kind and how much? \_\_\_\_\_

Unusual reaction to dental injections? \_\_\_\_\_

Reason for today's visit \_\_\_\_\_ Are you in pain? \_\_\_\_\_

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? \_\_\_\_\_

Do you have BiteWing x-rays that are less than 1 year old? \_\_\_\_\_

Name of former dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last cleaning and exam \_\_\_\_\_

Patient / Guardian Signature:

Date: