DENTAL POINT

PATIENT MEDICAL HISTORY FORM

Patient Information:

Full Name: _____ Date of Birth: _____
Address: _____ Phone: _____
Email: _____ Emergency Contact: _____

Medical History:

Are you currently under a physician's care? If yes, please specify reason: _____

Have you been hospitalized in the past 5 years? If yes, please specify reason: ____

Do you have any allergies or adverse reactions to medication? If yes, please specify:

Do you have any medical conditions we should be aware of? If yes, please specify:

Are you currently taking any medication? If yes, please specify: _____

Have you ever had a serious reaction to dental treatment? If yes, please specify: ____

Do you use tobacco or smoke? If yes, please specify: _____

Signature: _____ Date: _____

Please complete this form before your appointment and bring it with you to the dental office. This information will be kept confidential and is necessary for us to provide you with the best possible dental care.