JONATHAN M. DAVIS, DMD
FAMILY DENTISTRY

Name _____ Date_____

Telephone (Home)_____Telephone (Work)_____Date of Birth_____

Address_____ S.S.#_____

E-mail address _____(please print clearly)

Person to contact in case of emergency_____Telephone_____

Patient Medical History

Who is your physician?_____Telephone_____

When was your last visit to your physician?_____

	Yes	No
1. Are you under any medical treatment now?.....	____	____
2. Have you ever had a serious illness or major operation?.....	____	____
3. Have you ever had an allergic response to any drugs including penicillin?.....	____	____
4. Has a physician ever informed you that you had: A Heart Ailment or murmur?	____	____
5. High Blood Pressure?.....	____	____
6. Respiratory Disease?.....	____	____
7. Diabetes?.....	____	____
8. Rheumatic Fever?.....	____	____
9. Arthritis or Rheumatism?.....	____	____
10. Tumors or Growths?.....	____	____
11. Any Blood Disease?.....	____	____
12. Any Liver Disease?.....	____	____
13. Any Kidney Disease?.....	____	____
14. Any Stomach Disease?.....	____	____
15. Any Venereal Disease?.....	____	____
16. Hepatitis or Jaundice?.....	____	____
17. Have you tested positive for the HIV virus (AIDS)?.....	____	____
18. Have you ever had a drug or alcohol dependency?.....	____	____
19. Do you have a hip, knee or joint replacement?.....	____	____
20. Are you now taking any drugs or medications?.....	____	____
If yes, what are they? _____		
21. Do you have a history of seizures or epilepsy?.....	____	____
22. Have you ever had any bleeding problems or slowly healing wounds?.....	____	____
23. Have you ever required a blood transfusion?.....	____	____
24. Are you in general good health at this time?.....	____	____
25. Do you smoke?.....	____	____

Patient Dental History

26. Are you currently experiencing any discomfort in your mouth?.....	____	____
27. Have you ever experienced any bleeding from your gums?.....	____	____
28. Are any teeth sensitive to hot, cold, pressure or sweets?.....	____	____
29. Have you ever had any problems with previous dental treatment?.....	____	____
30. Do you ever wake up with jaw pain or headaches?.....	____	____
31. Have you ever had a broken jaw or lost a tooth from an injury?.....	____	____
32. Have you ever had x-ray treatment for a tumor of the head or neck?.....	____	____
33. When was your last full mouth x-ray taken?_____By Whom?_____		
34. At present, do you have any dental complaints?.....	____	____

I HAVE READ AND UNDERSTAND THE HIPAA POLICY FOR THIS OFFICE. I CONSENT TO ROUTINE DENTAL TREATMENT PROVIDED BY THIS OFFICE.

Patient Signature _____Date_____Reviewed_____