Magnolia Dental
family dentistry

Patient Information and Health

Patient's Name _____ Date of Birth _____
Sex: Male _____ Female _____ S.S.# _____
Address _____ Home Phone _____
City, State Zip _____ Work Phone _____
Email Address _____ Cell Phone _____
Referred By _____

Medical History

Please circle "Yes" or "No" to All questions.

1. Rheumatic Fever	Yes	No	13. Venereal Disease	Yes	No
2. Heart Problem	Yes	No	14. AID/HIV	Yes	No
3. Heart Murmur	Yes	No	15. Diabetes	Yes	No
4. Stroke	Yes	No	16. Epileptic Seizures	Yes	No
5. High Blood Pressure	Yes	No	17. Allergies	Yes	No
6. Prolonged Bleeding	Yes	No	18. Arthritis	Yes	No
7. Hepatitis/Jaundice	Yes	No	19. Valve Replacement	Yes	No
8. Kidney/Renal Diseases	Yes	No	20. Joint Replacement	Yes	No
9. Respiratory Problem	Yes	No	21. Thyroid Problems	Yes	No
10. Asthma	Yes	No	22. Anemia of Blood Problem	Yes	No
11. Tuberculosis	Yes	No		Yes	No
12. Emphyseme	Yes	No		Yes	No

Are you taking any medication of pills (prescribed or not)? Yes No
If yes, please list: _____
Are you allergic to any medications or drugs? Yes No
If yes, please list: _____
Are you under the care of a physician at the present time? Yes No
If yes, for what condition? _____
Women Only. Are you pregnant? Yes No
If yes, how many months? _____
Women Only. Are you taking birth control pills? Yes No

Dental History

Chief Oral Complaint _____

1. Do you have any pain near your ears? Yes No
2. Do you clench or grind your teeth? Yes No
3. Do your gums bleed upon brushing? Yes No
4. Have you ever had any extensive dental procedure? Yes No
5. When was your last full mouth x-ray taken? _____
6. When was the last time you've seen the dentist? _____

Patient's Signature _____
(If patient is under 18, parent or legal guardian must sign)