PARKWOOD
DENTAL ASSOCIATES, P.A.

MEDICAL HISTORY

Name _____ Date of Birth _____
Address _____ SS# _____
_____ Cell Phone _____- Marital Status _____
Home Phone _____ Email _____
Occupation _____
Place of Business _____ Work Phone _____
Dental Insurance Carrier _____ ID No. _____
Person Responsible for Account _____
Address _____ Referred By _____
_____
Physicians Name _____ Dr.Phone No. _____
Date of last physical exam _____ General Health _____
Are you under a physicians care now? _____
Are you allergic to any drugs? _____ If so, What? _____
Medication, drugs or pills taken in the last six months? _____

Do you have a history or currently have any of the following?

_____ Abnormal Blood Pressure	_____ Easily Winded	_____ Lung Disease
_____ AIDS/HIV	_____ Emphysema	_____ Multiple Sclerosis
_____ Allergies	_____ Epilepsy/Seizures	_____ Nervous Disorders
_____ Alzheimers	_____ Excessive Thirst	_____ Pacemaker
_____ Anaphylaxis	_____ Fainting Spells/Dizziness	_____ Pain in Jaw Joints
_____ Anemia	_____ Frequent Cough	_____ Psychiatric Treatment
_____ Angina	_____ Frequent Diarrhea	_____ Radiation/Chemotherapy
_____ Arthritis/Gout	_____ Glaucoma	_____ Respiratory Problems
_____ Artificial Joints	_____ Hay Fever	_____ Rheumatic Fever
_____ Artificial Heart Valve	_____ Head Injuries	_____ Rheumatism
_____ Asthma	_____ Heart Attack/Failure	_____ Scarlet Fever
_____ Bisphosphonates	_____ Heart Disease	_____ Shingles
_____ Bleeding Problems	_____ Heart Murmur	_____ Sickle Cell Disease
_____ Blood Disease	_____ Hemophilia	_____ Sinus Problems
_____ Breathing Problem	_____ Hepatitis	_____ Spinda Bifida
_____ Bruise Easily	_____ Herpes	_____ Stomach Problems
_____ Cancer	_____ Hives/Rash	_____ Stroke
_____ Chest Pains	_____ Hypoglycemia	_____ Swelling
_____ Cold Sores/Fever Blisters	_____ Irregular Heartbeat	_____ Tuberculosis
_____ Congenital Heart Disorder	_____ Jaundice	_____ Thyroid Disorder
_____ Convulsions	_____ Kidney Disease	_____ Tonsilitis
_____ Cortisone Medication	_____ Latex Allergy	_____ Tumors
_____ Diabetes	_____ Leukemia	_____ Ulcers
_____ Drug Addiction	_____ Liver Disease	_____ Weight Loss

TODD R. SANDER, DMD
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DENTAL HISTORY

Have you ever had a blood transfusion? _____
Have you ever had a serious illness not listed above? _____
Are you on a special diet? _____
Are you pregnant? _____ Expected delivery date? _____
Do you use tobacco? _____ How much? _____ How Often? _____
Date of last dental visit? _____ How often do you brush your teeth? _____
Do you use dental floss?_____ How Ofen? _____
Do your gums bleed? _____ When? _____
Do you have bad breath? _____ Does food get lodged between your teeth?_____
Are your teeth sensitive? _____ Describe _____
How do you feel about your teeth in general? _____
Do you like your smile? _____
Are you in any dental discomfort? _____
Are you apprehensive about dental care? _____
Do you have an interest in cosmetic dentistry? _____

I _____, have received a copy of this office's
PLEASE PRINT NAME
Notice of Privacy Practices (HIPAA).

_____ _____
SIGNATURE DATE

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