Long Beach Dental Arts
Medical History

Name:_____ **Today's Date**:_____
DOB: ___/___/___ Age:_____ Social Security#:_____ DL#:_____
Home Address:_____City:_____Zip:_____
Hm Ph#: (___)_____ Wrk#: (___)_____Ext:____ Pager/Cell#: (___)_____

Do you have a physical physician? Yes No
Physician's Name:_____
Address:_____
Phone#:_____ Date of last visit:_____ Current Physical Health: Good Fair Poor

Are allergic to anything?:

Y N Aspirin	Y N Erythromycin	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Jewelry/ Metals	Y N Sulfa Drugs	Y N Penicillin
Y N Codeine	Y N Latex	Y N Dental Anesthetics	Y N Other

Please list other drugs/ materials that cause allergic reactions:

_____

_____

Are you taking any of the following? (If **YES**, please specify name of medication)

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes	Y N Thyroid Med.
Y N Antibiotics	Y N Blood Press Med.	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	
Y N Aspirin	Y N Digitalis/ Heart	Y N Steroids/Cortisone	

Are you taking any prescription/ over-the-counter-drugs not listed above? Yes No if yes please list:

For Women: Are you taking birth control pills? Yes No
Are you pregnant? Unsure Yes No
Week#_____ Are you nursing? Yes No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Difficulty Swallowing	Y N Heart Attack	Y N Psychiatric Problems
Y N Alcohol Abuse	Y N Dizziness	Y N Heart Murmur	Y N Radiation Treatment
Y N Anemia	Y N Drug Abuse	Y N Heart Surgery	Y N Rheumatic Fever
Y N Arthritis	Y N Dry Mouth	Y N Hemophilia	Y N Ringing in Ears
Y N Artificial Bones/Joints	Y N Emphysema	Y N Hepatitis A B or C (**circle**)	Y N Scarlet Fever
Y N Artificial Valves	Y N Epilepsy	Y N Herpes	Y N Seizures
Y N Asthma	Y N Excessive Thirst	Y N High Blood Pressure	Y N Shingles
Y N Blood Transfusion	Y N Fainting Spells	Y N HIV+/ AIDS	Y N Sickle Cell Disease
Y N Cancer	Y N Fen-Phen	Y N Hospitalized for any Reason	Y N Sinus Problems
Y N Chemotherapy	Y N Fever Blisters	Y N Kidney Problems	Y N Steroid Therepy
Y N Chest Pain	Y N Frequent Urination	Y N Liver Disease	Y N Stroke
Y N Colitis	Y N Glaucoma	Y N Low Blood Pressure	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N Hay Fever	Y N Lupus	Y N Tonsillitis
Y N Diabetes	Y N Headaches	Y N Mitral Valve Prolapse	Y N Tuberculosis (TB)
Y N Difficulty Breathing	Y N Pacemaker	Y N Persistent Cough	Y N Venereal Disease

Y N Family history of: (**circle**) Diabetes / Heart Problems / Tumors
Please list any serious medical condition(s) that you have experienced: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need, including but not limited to x-rays, examinations, and diagnostics tests. I have provided an opportunity to review the Notice of Privacy Practices. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature_____Date_____ Doctor sig:_____