Medical History

Dr. Danilo Hernández, D.D.S.

Please complete Dental History Information on reverse side.

PATIENT INFORMATION

PATIENT'S NAME (Last, First, M.I.)	SEX [ ] M [ ] F	BIRTHDATE	AGE

SOCIAL SECURITY NO.	IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME	TODAY'S DATE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	REASON FOR THIS VISIT

PHYSICIAN NAME	PHYSICIAN ADDRESS	PHYSICIAN PHONE NUMBER

RESPONSIBLE PARTY INFORMATION

NAME (LAST, FIRST, M.I.	MARITAL STATUS

ADDRESS (Street, City, State, Zip Code)

HOW LONG AT THIS ADDRESS	HOME PHONE	WORK PHONE

SOCIAL SECURITY NO.	BIRTHDATE	DRIVER'S LICENSE NO.	RELATION TO PATIENT

EMPLOYER	OCCUPATION	NO. YEARS EMPLOYED

RESPONSIBLE PARTY'S SPOUSE

NAME (Last, First, M.I.)	SOCIAL SECURITY NO.

EMPLOER	OCCUPATION

NO. YEARS EMPLOYED	WORK PHONE	BIRTHDATE

UPDATES

DATE	DR. SIGNATURE	DATE	DR. SIGNATURE

MEDICAL HISTORY - Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE THE FOLLOWING, If yes, please indicate "yes" and circle illness:

	YES	NO
1. Asthma, hay fever sinusitis, or other allergies	[ ]	[ ]
2. Allergy to penicillin, aspirin, local or general anesthetic, or other drugs: specify:	[ ]	[ ]
3. Blood pressure or heart problems	[ ]	[ ]
4. Rheumatic fever or heart murmur or mitral valve prolapse	[ ]	[ ]
5. A pacemaker or open heart surgery or heart valve replacement	[ ]	[ ]
6. Diabetes, liver, kidney, thyroid, or lung problems	[ ]	[ ]
7. Ulcer or stomach problems	[ ]	[ ]
8. Hepatitis or Jaundice	[ ]	[ ]
9. Epilepsy or nervous disorders	[ ]	[ ]
10. Bleeding or clotting disorders	[ ]	[ ]
11. Arthritis or hip replacement surgery or prosthetic joint replacement	[ ]	[ ]
12. Venereal Disease, Herpes	[ ]	[ ]
13. Acquired Immune Deficiency Syndrome (AIDS) / A.R.C. / HIV Positive	[ ]	[ ]
14. Any other illness	[ ]	[ ]
15. Do any wounds heal slowly or present complications?	[ ]	[ ]
16. Are you presently taking any medicine? Specify:	[ ]	[ ]
17. Are you presently under the care of a physician?	[ ]	[ ]
18. When was your last physical exam?	[ ]	[ ]
19. Have you ever been hospitalized? Date: Reason:	[ ]	[ ]
20. Have you had X-ray treatments or chemotherapy?	[ ]	[ ]
21. Are you presently on a diet?	[ ]	[ ]
22. Women [ ] Are you taking birth control pills? [ ] Are you pregnant?	[ ]	[ ]

PATIENT SIGNATURE	DATE	DOCTOR SIGNATURE	DATE

Dental History

Please complete Medical History information on reverse side.

DENTAL INSURANCE INFORMATION (Primary Carrier)		
INSURED'S NAME		
INSURANCE COMPANY		
INSURANCE COMPANY ADDRESS		
INSURED'S EMPLOYER		
INSURED'S SOCIAL SECURITY NO	GROUP NO	LOCAL NO

DATE OF LAST DENTAL EXAM	DATE OF LAST FULL MOUTH X-RAY	WHERE TAKEN

		YES	NO
1	Have you had trouble from previous dental care?	[ ]	[ ]
2	Do you have pain in your jaw or near your ears?	[ ]	[ ]
3	Do you have any unhealed injuries or imflamed areas in or around your mouth?	[ ]	[ ]
4	Have you experienced any growths or sore spots in your mouth?	[ ]	[ ]
5	Does any part of your mouth hurt when clenched?	[ ]	[ ]
6	Have you ever had Novocaine or other local anesthetic?	[ ]	[ ]
7	Have you ever had Nitrous Oxide (laughing gas)?	[ ]	[ ]
8	Have you ever had general anesthesia?	[ ]	[ ]
9	Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics?	[ ]	[ ]
10	Have you ever had any difficult extractions in the past	[ ]	[ ]
11	Have you ever had prolonged bleeding following extractions in the past?	[ ]	[ ]
12	Do your gums bleed?	[ ]	[ ]
13	Do you have a bad taste in your mouth or mouth odor?	[ ]	[ ]
14	Have you ever had instructions on the care of your gums?	[ ]	[ ]
15	Do you chew on only one side of your mouth? If so, why?	[ ]	[ ]
16	Do you habitually clench or grind your teeth during the night or day?	[ ]	[ ]
17	Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?	[ ]	[ ]

Is there any other problem not covered above that you would like to discuss?

PATIENT SIGNATURE	DATE	DOCTOR SIGNATURE	DATE