L. KING SCOTT, D.D.S.

FAMILY DENTISTRY

MEDICAL HISTORY UPDATE

PLEASE PRINT OR WRITE LEGIBLY.

Name	Social Security Number	Sex	Birthdate	Race	What do your friends call you?

Address: Street	City	State	Zip Code	Home Phone	Marital Status	Spouse's Name

Responsible Party: Name	Social Security: # / Relationship to child:	Employer:	Office Phone:

Do you have insurance that may cover any part of our professional services? ☐ Yes ☐ No If so, name of company:	Spouse's Employer:	Spouse's Office Phone:

Dr. License #	Highest grade attained in school 1 2 3 4 5 6 7 8 9 10 11 12	College 1 2 3 4 5 6 7 8 *	Your E-Mail Address

Please RANK the following reasons in the order (#1 thru #4) in which they would KEEP YOU FROM having dental treatment.

FEAR of pain – #_____ LACK of concern – #_____ COST of treatment – #_____ MISSING work time – #_____

Cell #

IN CASE OF EMERGENCY, PLEASE NOTIFY

Name	Relation

Address	Phone

Are you being treated by a Medical Doctor now? 1. ☐ Yes ☐ No	If Yes, for what reason?
Are you taking any drugs or medicine at the present time, including birth control pills? 2. ☐ Yes ☐ No	What? (Cont. on next line)

Meds

Medical Doctor's Name / Last Exam	If child - approximate weight/ height
3.	
Are you sensitive or allergic to any medicine, including penicillin? 4. ☐ Yes ☐ No	If Yes, what, including penicillin?
Have you ever been hospitalized or had any surgical operations? 5. ☐ Yes ☐ No	If Yes, list reasons and dates.
Have you ever had a blood transfusion? If yes, give reason 6. ☐ Yes ☐ No	Are you sensitive to iodine?

7. HAVE YOU HAD:

a. ASTHMA OR HAY FEVER ..... Yes
b. TUBERCULOSIS ..... Yes
c. RHEUMATIC FEVER, RHEUMATIC HEART DISEASE ..... Yes
d. SCARLET FEVER ..... Yes
e. HEART MURMUR ..... Yes
f. HEART DISEASE OR HEART ATTACK ..... Yes
g. ANGINA PECTORIS ..... Yes
h. STROKE ..... Yes
i. HIGH BLOOD PRESSURE ..... Yes
j. LOW BLOOD PRESSURE ..... Yes
k. ANEMIA ..... Yes
l. ALLERGIES OR HIVES ..... Yes
m. ULCERS (Stomach or intestinal) ..... Yes
n. ARTHRITIS ..... Yes
o. HIV POSITIVE – AIDS ..... Yes
p. HERPES SIMPLEX II ..... Yes
q. VENEREAL DISEASE (i.e.; Syphilis, Gonorrhea, etc.) ..... Yes
r. KIDNEY OR BLADDER DISEASE ..... Yes
s. HEPATITIS A ..... Yes
t. HEPATITIS B ..... Yes
u. GALL BLADDER DISEASE ..... Yes
v. DIABETES (Sugar Disease) ..... Yes
w. NERVOUSNESS ..... Yes
x. EPILEPSY OR SEIZURES ..... Yes
y. FAINTING OR DIZZY SPELLS ..... Yes
z. GLAUCOMA ..... Yes
aa. PACEMAKER ..... Yes
bb. THYROID DISEASE (or Goiter) ..... Yes
cc. PSYCHIATRIC TREATMENT ..... Yes
dd. CHEMOTHERAPY - RADIATION THERAPY (Cancer, Leukemia) ..... Yes
ee. ARE YOU PREGNANT? ..... Yes
ff. HAVE YOU EVER HAD EXCESSIVE BLEEDING FROM CUT OR WOUND? ..... Yes
gg. HAVE YOU HAD ANY TROUBLE OR REACTIONS TO LOCAL OR GENERAL ANESTHETICS? ..... Yes
hh. DO YOU CLENCH OR GRIND YOUR TEETH? ..... Yes
ii. ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH? ..... Yes
jj. HAVE YOU EVER BEEN INSTRUCTED IN CARING FOR YOUR TEETH AND GUMS? ..... Yes
kk. ARE YOU INTERESTED IN A PREVENTIVE DENTAL PROGRAM? ..... Yes
ll. ARE YOU INTERESTED IN COSMETIC DENTISTRY? ..... Yes
mm. DO YOU HAVE SKIN REACTIONS TO METAL JEWELRY? ..... Yes

I, THE UNDERSIGNED (PARENT OR LEGALLY RESPONSIBLE PARTY), (A) CERTIFY THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND CORRECT; (B) AUTHORIZE DENTAL TREATMENT TO BE RENDERED BY THE DENTIST AND HIS STAFF; (C) UNDERSTAND AND ACCEPT THAT I WILL BE RESPONSIBLE FOR PAYMENT FOR THIS TOTAL FEE REGARDLESS OF MY DENTAL INSURANCE BENEFITS.

SIGNATURE_____ DATE_____