Dr. Darren K. Dickson, D.D.S.

Confidential Medical-Dental History Form

Date ______________

Patient's Name ____ Gender _______

Last First Middle Nickname

Address ____

Street City State Zip Code

____

Home Cell Work

____

Social Security E-mail Birth Date

What is the best way to contact you? ______________

Who may we thank for referring you? ________________________________

Tell us what's important to you in finding a dentist: ____

____

Medical History

Are you now or have you recently been under a physician's care? ________ Yes ________ No

Reason: ____

. Circle any of the following, which you have had or have at present:

Heart Failure	Emphysema	HIV/AIDS	Prostate Problems
Heart Disease or Attack	Cough/Persistent	Hepatitis A (infectious)	Multiple Sclerosis
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)	Mouth Ulcers
High Blood Pressure	Asthma	Liver Disease	Alcoholism
Heart Murmur	Hay Fever	Yellow Jaundice	Drug Dependency
Rheumatic Fever	Sinus Trouble	Blood Transfusion	Cancer/Tumors
Congenital Heart Lesions	Allergies or Hives	Drug Addiction	Epilepsy or Seizures
Scarlet Fever	Diabetes	Hemophilia	Arthritis
Artificial Heart Valve	Thyroid Disease-Hyper/Hypo	Cosmetic Surgery	Bruise Easily
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores	Fever Blisters
Heart Surgery	Chemotherapy	Fainting or Dizzy Spells	Anemia
Stroke	Rheumatism	Nervousness	Pain in Jaw Joints (TMD)
Kidney Trouble	Cortisone Medicine	Psychiatric Treatment	Glaucoma
Stomach Ulcers	Sickle Cell Disease	Venereal Disease (Syphilis, Gonorrhea, Herpes)	
Artificial Joints (Hip, Knee)			

Are you taking any medication? ________ Yes _________ No

If yes, please explain: ______________________________

Are you allergic to anything? _________Yes __________No

If yes, please list: ________________________________

Are you pregnant? _________Yes _________No

If yes, how many months? ______________

□ I certify that the above information is true and correct and I allow Dr. Dickson use my testimonial, photos and name to let other patients learn about my great experience with your office.

Patient Signature: ______________________Witness:______________________