Lakeview Dental Ltd.

Medical History Form

Name_____Home Phone #_____
Last **First** **MI**

Home Address, City, ST, Zip_____

Mailing Address (if different from above) _____

Work Phone #_____Cell Phone # _____ **Preferred Contact Phone #**_____

Social Security #_____ Sex M F E-mail _____

Birth Date _____/_____/_____ Single_____ Married_____ Widowed_____ Divorced _____ Other_____

Employer_____ Occupation_____

Spouse's name_____ Spouse's Employer_____ Occupation_____

(*IF STUDENT OR CHILD*) Fathers name & Employer_____

(***IF STUDENT OR CHILD***) Mothers name & Employer _____

Emergency contact name & phone #_____

Person(s) Responsible for the account_____

DENTAL INSURANCE: Name of Company_____

Subscriber Name_____ Policy/ID # _____Group #_____

#2 DENTAL INSURANCE: Name of Company _____

Subscriber Name _____ Policy/ID # _____Group # _____

For the following questions, *CIRCLE YES OR NO* whichever applies. Your answers are for our records only and will be considered confidential. *Please note* that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Has there been any change in your general health within the past year? **……YES NO**
IF YES please explain. _____

2. Are you under the care of a physician other than regular check ups? **…….YES NO**
IF YES what is the condition being treated? _____

3. The name of your physician(s) is _____

4. Have you had any serious illness, operation or been hospitalized in the past 3 years**? ……. ……. ……YES NO**
IF YES what was the illness or problem? _____

5. Are you taking any medicines(s) including non-prescription medicine? **……..YES NO**
IF YES what are you currently taking? _____

6. ***PLEASE CIRCLE YES OR NO*** **if you now have, or have had any of the following disease or problems.**

Abnormal Blood Pressure …… (if you are on medication to control, please circle YES)..……...**YES NO**
Damaged heart valves or artificial heart valves ……..**YES NO**
Heart murmur of rheumatic heart disease ……..**YES NO**
Inborn heart defects ……**YES NO**
Do you have a cardiac pacemaker? ……**YES NO**
Heart trouble, Heart attack, arteriosclerosis, angina, etc**.** …….. **YES NO**
Stroke …….. **YES NO**
Joint replacements (HIP KNEE etc.) ……..**YES NO**
Do you need to be pre-medicated with antibiotics for dental work due to any of the above? ……**YES NO**

PLEASE TURN PAGE OVER AND COMPLETE SIDE 2