

**J. Richard Lawrence, D.D.S., P.C
MEDICAL/DENTAL HISTORY FORM**

PATIENT INFORMATION				Today's date:
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Marital status (circle one) Single Married Divorced Separated Widowed			Birth date: Age: Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Patient's Street Address:		Social Security no.:	Home phone no.: ()	
City:	State:	ZIP Code:	Cell phone no.: ()	
Occupation:	Employer:	Employer phone no.: ()		

DENTAL INSURANCE FORM				
Name of Insurance Company:		Mailing Address	City	State Zip
Name of Person Insured		Member/ID #	Group #	Insured's SS#
Insured's Date of Birth	/ /	Patient's Relation to Insured (circle one) Self Spouse Child Other (please explain)		

DENTAL HISTORY				
Last Dental Visit:	/ /	Any Dental Work Being Done Now	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes What?
Has Patient Ever received a Blow to the Teeth or Jaw?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain?	
Name of Person Insured		Member/ID #	Group #	

MEDICAL HISTORY				
Name of Physician	Physician's Phone No. ()	Physicians Address:	City	State Zip

Certain illnesses & drugs may make it necessary to alter our treatment. In our endeavor the best possible oral healthcare to you (or your child), it is necessary to have the following information. Do you have or EVER had any of the following? If yes, ok please indicate & **CIRCLE illness:**

Asthma, hay fever, sinusitis, or other allergies / El asma, fiebre del heno, sinusitis, u otras alergias	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy to penicillin, aspirin, local or general anesthetic, or other drugs? Specify / La alergia a la penicilina, aspirina, anestesia local o general, o de otras drogas? Especificar	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure or heart problems? / Problemas de Corazon o presion arterial	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever, heart murmur or mitral valve prolapse / La fiebre reumática, soplo cardiaco o prolapso de la válvula mitral	<input type="checkbox"/> Yes <input type="checkbox"/> No
A pacemaker, open heart surgery, or heart valve replacement / Un marcapasos, cirugía a corazón abierto, o el reemplazo de la válvula del corazón	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes, liver, kidney, thyroid or lung problems / La diabetes, hígado, riñón, tiroides o problemas pulmonares	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcer or stomach problems / Úlcera o problemas estomacales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis or jaundice / Hepatitis o ictericia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy or nervous disorders / Epilepsia o trastornos nerviosos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding or clotting problems / Sangrado o problemas de coagulación	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, hip replacement or prosthetic joint replacement / Artritis, reemplazo de cadera o reemplazo de la articulación protésica	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communicable diseases: tuberculosis, herpes or venereal / Las enfermedades transmisibles: tuberculosis, herpes o venéreas	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/A.R.C./HIV Positive / SIDA / A.R.C. / VIH positivos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other illnesses? / Cualquier otra enfermedad?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do wounds heal slowly or present complications? / No heridas cicatrizan lentamente o presentar complicaciones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you presently taking any medications? Specify / Si usted actualmente tomando algún medicamento? Especificar	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you presently under the care of a physician? / ¿Esta usted actualmente bajo el cuidado de un médico?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized? / ¿Alguna vez ha estado hospitalizado?	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason/Razón
Have you ever had x-ray treatments or chemotherapy? / ¿Alguna vez has tenido tratamientos de rayos X o quimioterapia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
WOMEN: Are you taking birth control pills? / MUJERES: ¿Está tomando pastillas anticonceptivas?	<input type="checkbox"/> Yes <input type="checkbox"/> No
WOMEN: Are you pregnant? / MUJERES: ¿Está embarazada?	<input type="checkbox"/> Yes <input type="checkbox"/> No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature	Doctor's Signature	Date
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PLEASE PRINT