William W. Schell, DDS, MAGD, FACD

Name_____ Date of Birth _____ Driver's license # _____

Home Address _____ City _____State _____ Zip _____

Billing Address_____City _____State_____ Zip _____

Tel# _____wk_____cell_____Email_____

May we leave a message concerning appointments ? _____ Treatment ? _____ Finances ? _____

Emergency # _____ Emergency Contact _____

Primary Dental Insurance _____ Group#_____ ID#_____

Employer _____

Subscriber _____ Date of Birth_____ SS#_____

Secondary Dental Insurance _____ Group# _____ ID# _____

Employer _____

Subscriber _____ Date of Birth _____ SS# _____

Physician _____ Date of Last visit to medical doctor _____

Previous Dentist _____ Date of Last Visit to Dentist _____

Health History

Have you had any serious illness, operation or hospitalization within the past 5 years? Yes No

Have you been told you need to take medication before dental procedures ? Yes No

Do you have or have you had any of the following problems?

Damaged Heart Valves, Rheumatic Heart Disease, Cardiac Stent Yes No

Joint Replacement Yes No

High Blood Pressure, Heart Condition Yes No

Sinus Trouble, Asthma or Respiratory Problems Yes No

Fainting Spells or Seizures Yes No

Tuberculosis, Persistent Cough or Cough that Produces Blood Yes No

Diabetes Yes No

Hepatitis, Jaundice or Liver Disease Yes No

Digestive Disorders Yes No

Kidney Disease Yes No

Persistent Swollen Neck Glands, Immune System Problems Yes No

Abnormal Bleeding, Blood Transfusion or Anemia Yes No

Cancer or Cancer Treatment Yes No

Do you use tobacco products? Yes No

Are you Pregnant or Nursing? Yes No

Are you allergic or have you had reaction to: (please circle)

Local Anesthetics Penicillin Sulfa Drugs Barbiturates Sleeping Pills Codeine Aspirin Tylenol

Latex Foods Plant Other (please specify) _____

Is there any other information that you think we should have?

_____

Medications list or attach:

_____

_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any error or omissions that I may have made in the completion of this form.

X _____

Signature of patient or guardian date

MEDICAL HISTORY UPDATE	**COMMENTS**	**DATE**
_____	_____	_____
_____	_____	_____
_____	_____	_____