

Medical Form

Date: _____ Email: _____
 Name (*first and last*): _____ D.O.B.: _____ Sex: _____
 Address (*street*): _____
 City, State, Zip: _____
 Home Phone: _____ Work Phone: _____ Mobile: _____
 Circle one: Married Single Divorced Widowed S.S.# _____
 Occupation: _____ Employer: _____
 Employer Address: _____ Phone: _____
 General Dentist: _____ Phone: _____
 Dental Insurance Carrier: _____
 Emergency Contact: _____ Phone: _____
 Whom may we *thank* for referring you today? _____

Dental History

Reason for today's visit _____
 Former Dentist _____ City/State _____
 Date of last dental visit _____ Date of last dental X-rays _____

For Children

Father Name: _____ Mother Name: _____
 D.O.B. _____ S.S.# _____ D.O.B. _____ S.S.# _____
 Occupation _____ Work phone _____ Occupation _____ Work phone _____

Place a circle "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	Yes	No	Loose teeth or broken fillings	Yes	No
Bleeding Gums	Yes	No	Orthodontic treatment	Yes	No
Burning sensation on tongue	Yes	No	Mouth pain, brushing	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No	Pain around ear	Yes	No
Clicking or popping jaw	Yes	No	Periodontal Treatment	Yes	No
Dry mouth	Yes	No	Sensitivity to cold	Yes	No
Food collection between the teeth	Yes	No	Sensitivity to heat	Yes	No
Grinding teeth	Yes	No	Sensitivity to sweets	Yes	No
Gums swollen or tender	Yes	No	Sensitivity when biting	Yes	No
Jaw pain or tiredness	Yes	No	Sores or growths in your mouth	Yes	No

Medications

Have you ever taken any of the following medications? FOSAMAX _____ BONIVA _____ ACTONEL _____

List any other medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____ Phone (_____) _____

Are you taking any medications at this time Yes No
 Are you under medical care Yes No
 Have you had any unfavorable reaction(s) to dental/medical care Yes No
 Any previous hospitalizations Yes No
 Date of your last dental exam _____
 Date of your last medical exam _____
 If you answered Yes to any of these, please explain:

Allergies
 Aspirin
 Local Anesthetic
 Barbiturates (Sleeping pills)
 Penicillin Codeine
 Sulfa
 Iodine
 Latex
 Other _____

Women
 Are you pregnant?
 Yes No
 Due date _____
 Are you nursing?
 Yes No
 Taking birth control pills?
 Yes No

Medical History

Do you have or had any of the following:

AIDS/HIV	Yes	No	Jaundice	Yes	No
Epilepsy	Yes	No	Swollen Neck Glands	Yes	No
Respiratory Disease	Yes	No	Cancer	Yes	No
Anemia	Yes	No	Jaw Pain	Yes	No
Fainting or dizziness	Yes	No	Thyroid Problems	Yes	No
Rheumatic Fever	Yes	No	Chemical Dependency	Yes	No
Arthritis, Rheumatism	Yes	No	Kidney Disease	Yes	No
Glaucoma	Yes	No	Tonsillitis	Yes	No
Scarlet Fever	Yes	No	Chemotherapy	Yes	No
Artificial Heart Valves	Yes	No	Liver Disease	Yes	No
Headaches	Yes	No	Tuberculosis	Yes	No
Shortness of Breath	Yes	No	Circulatory Problems	Yes	No
Artificial Joints	Yes	No	Low Blood Pressure	Yes	No
Heart Murmur	Yes	No	Tumor or growth on head	Yes	No
Sinus Trouble	Yes	No	Congenital Heart Lesions	Yes	No
Asthma	Yes	No	Mitral Valve Prolapse		
Heart Problems	Yes	No	or neck	Yes	No
Skin Rash	Yes	No	Cortisone Treatments	Yes	No
Back Problems	Yes	No	Nervous Problems	Yes	No
Hepatitis Type	Yes	No	Ulcer	Yes	No
Special Diet	Yes	No	Cough, persistent or bloody	Yes	No
Bleeding abnormally, with			Pacemaker	Yes	No
extractions or surgery	Yes	No	Venereal Disease	Yes	No
Herpes	Yes	No	Diabetes	Yes	No
Stroke	Yes	No	Psychiatric Care	Yes	No
High Blood Pressure	Yes	No	Weight Loss, unexplained	Yes	No
Swollen Feet or Ankles	Yes	No	Emphysema	Yes	No
Blood Disease	Yes	No	Radiation Treatment	Yes	No

I hereby authorize Dr. Jacqueline Fulop-Goodling and/or her associates to render any services deemed necessary in my treatment.

Date: _____ **Signature:** _____

Please note: A panoramic radiograph is required at your consultation. If you do not have one, we will take one for you. The fee is \$75.00 and must be paid in full on the day of your consultation

