WRIGHT DENTURES & DENTAL CARE
Your affordable home for custom dentures and great smiles.

ACCT # _____

MEDICAL HISTORY **PLEASE PRINT**

PATIENT FULL NAME _____ PATIENT DATE OF BIRTH _____
Address/City/State/Zip _____
Home Phone Number: _____ Cell Number _____
Patient Social Security # _____ Parent/Guardian SS# _____
Parent/Guardian Name _____ Parent/Guardian Date of Birth _____
Insured is: (circle one) Patient Parent/Guardian Other _____

Please supply insured information if different from above.
Name _____ Date of Birth _____
Social Security # _____ Employer _____ Phone # _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive.

Are you allergic to any of the following? (Please circle any that apply)
Aspirin Penicillin Codeine Acrylic Metal Latex Erythromycin
Local Anesthetics Sulfa Ultram Other _____

Women: Pregnant YES NO Due date _____

Do you or have you had any of the following conditions? Circle any that apply.

AIDS/HIV Positive	Drug Addiction	Kidney Problems	**Do you take:**
Anemia	Emphysema	Osteoporosis	**Aspirin Daily?**
Arthritis	Epilepsy	Low Blood Pressure	**Blood Thinner Daily?**
Artificial Heart Valve/Stints	Excessive Bleeding	Liver Disease	
Artificial Joint(s)	Fainting/Dizziness	Lung Disease	
Asthma	Heart Attack/Failure	Mitral Valve Prolapse	**Previous Patients Only.**
Blood Disease	Heart Murmur	Pain in Jaw Joints	**Any changes in Health History?**
Blood Transfusion	Heart Pace Maker	Prolonged Bleeding	
Breathing Problems	Heart Trouble/Disease	Radiation Treatments	**YES** **NO**
Cancer/Leukemia	Hepatitis A B or C	Rheumatic Fever	
Chemotherapy	Head Injuries	Scarlet Fever	_____
Congenital Heart Disorder	High Blood Pressure	Sinus Trouble	Initial's Today's Date
Convulsions	Hypoglycemia	Stroke	
Diabetes	Irregular Heartbeat	Tuberculosis	

Have you ever had a fractured jaw? YES NO Date _____

Please list any other conditions not listed above and date of diagnosis.

_____ _____ _____

Please list current medications you are taking. You may also supply us with a written list. We will be happy to copy your list.

_____ _____ _____

_____ _____ _____

To the best of my knowledge, the questions on this form have been accurately answered.
I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
I (or patient) have no other existing or past medical conditions.

_____ _____
Signature of patient, parent or guardian Today's Date

How did you hear about our office? _____