Employee's Paylocity ID: _____

Medical History

PERSONAL INFORMATION

Patient Name: First _____ M Last _____ DOB: MM / DD / YY _____

Languages Spoken: ☐ English ☐ Spanish ☐ Other: _____

Ethnicity: _____ Race: _____

DENTAL INFORMATION

Are you having any pain or sensitivity at this time (or recently)? ☐ No ☐ Yes, Please Explain:

_____

Do you have any dental problems right now that you are aware of? ☐ No ☐ Yes, Please Explain:

_____

MEDICAL INFORMATION

Are you, or do you think you may be pregnant? ☐ No ☐ Yes

Are you being treated by a physician now?	☐ No ☐ Yes	Reason:	_____
Taking any medications?	☐ No ☐ Yes	Identify:	_____
Allergic to any medications?	☐ No ☐ Yes	Identify:	_____
Allergic to metals?	☐ No ☐ Yes	Identify:	_____
Any recent serious illnesses?	☐ No ☐ Yes	Identify:	_____
Have you ever had any major surgery?	☐ No ☐ Yes	Identify:	_____

Please ☐ CHECK any of the following which you have had (or presently have).

☐ Heart Trouble	☐ Stroke	☐ High Blood Pressure	☐ Diabetes
☐ Rheumatic Fever	☐ Kidney/Liver Disorder	☐ Eye Disorder	☐ Tumors/Growths Prolonged
☐ Bleeding	☐ Tuberculosis	☐ Asthma	☐ Epilepsy
☐ Hepatitis	☐ AIDS (HIV+)	☐ Venereal Disease	☐ Arthritis
☐ Allergic to Anesthetic	☐ Smoking or Chewing	☐ Thyroid Condition	☐ Stomach/Intestinal Problems
☐ Birth Control Pills	☐ Heart Murmur	☐ Artificial Heart Valve	☐ Ulcers
☐ Latex Sensitivity	☐ Cold Sores/Fever Blisters	☐ Fainting or Dizzy Spells	☐ Bruise Easily
☐ Psychiatric/Psychological Care			

Are there any other medical problems that we should be aware of? ☐ No ☐ Yes, Please Explain:

_____

The information above is accurate to the best of my knowledge.

X _____

Signature Print Name Date