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

PATIENT INFORMATION			Today's date:
Patient's last name:	First:	Middle:	❑ Mr.❑ Mrs. ❑ Miss❑ Ms.
Marital status (circle one) Single Married Divorced Separated Widowed			Birthdate: / / Age: Sex: ❑ M ❑ F
Patient's Street Address:		Social Security no.:	Home phone no.: ( )
City:	State:	ZIP Code:	Cell phone no.: ( )

PRIMARY INSURANCE			
Name of Insurance Company:			
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)		

SECONDARY INSURANCE			
Name of Insurance Company:			
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)		

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. Have you EVER had any of the following?

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

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

Patient/Guardian signature　　Doctor's Signature　　Date

PLEASE PRINT