JOHN C. MACHELL, DMD, MAGD, PLLC
Comprehensive Dental Care
Master Academy General Dentistry

Date ____________

Referred By ____________

Name ____________ Birth Date ____________ Age ____________

Residence: Street ____________ City ____________ State ____________ Zip ____________

Telephone: Home ____________ Cell ____________ Business ____________ E-Mail ____________

Responsible Party ____________ ☐ College Student Where? ____________

You Are Employed by ____________ Position ____________ How long held ____________

Business Address ____________ City ____________ State ____________ Zip ____________

Name of Dental Insurance Co. ____________ Group # ____________ S.S. # ____________

Name of Spouse/Parent ____________

Spouse Employed by ____________ Position ____________ How long held ____________

Business Address ____________ City ____________ State ____________ Zip ____________

Name of Dental Insurance Co. ____________ Group # ____________ S.S. # ____________

How may we help you? ____________

____

____

Name of Physician ____________ Telephone # (if known) ____________

	CIRCLE	
1. Have you been under the care of a medical doctor in the last two years?	YES	NO
2. Have you taken any medication or drugs during the past two years?	YES	NO
What medications? ____________		
3. Have you been a patient in the hospital during the past two years?	YES	NO
4. Are you allergic to penicillin, aspirin, codeine, or any drugs or medications?	YES	NO
5. Have you ever been pre-medicated for dental treatment?	YES	NO
6. Have you ever had any excessive bleeding requiring special treatment?	YES	NO
7. Do you have any skin reaction to certain metals?	YES	NO
8. Are you on a special diet?	YES	NO
9. WOMEN: Are you pregnant?	YES	NO

10. Check any of the following which you have had or have at present:

	YES	NO		YES	NO		YES	NO
Heart Failure	☐	☐	Asthma	☐	☐	Blood Transfusion	☐	☐
Heart Disease or Attack	☐	☐	Hay Fever	☐	☐	Hemophilia	☐	☐
Angina Pectoris	☐	☐	Sinus Trouble	☐	☐	Sickle Cell Disease	☐	☐
Heart Murmur	☐	☐	Allergies or Hives	☐	☐	Cold Sores	☐	☐
Rheumatic Fever	☐	☐	Diabetes	☐	☐	Genital Herpes	☐	☐
Congenital Heart Lesions	☐	☐	Thyroid Disease	☐	☐	Venereal Disease	☐	☐
Heart Surgery-Prothesis	☐	☐	Arthritis	☐	☐	AIDS	☐	☐
High Blood Pressure	☐	☐	Cortisone Medicine	☐	☐	Radiation Treatment	☐	☐
Stroke	☐	☐	Liver Disease	☐	☐	Chemotherapy	☐	☐
Artificial Joint	☐	☐	Yellow Jaundice	☐	☐	Psychiatric Treatment	☐	☐
Ulcers	☐	☐	Hepatitus A (Infectious)	☐	☐	Nervousness	☐	☐
Kidney Trouble	☐	☐	Hepatitus B (Serum)	☐	☐	Fainting or Dizzy Spells	☐	☐
Tuberculosis	☐	☐	Hepatitus C	☐	☐	Epilepsy or Seizures	☐	☐
Emphysema	☐	☐	Anemia	☐	☐	Drug Addition	☐	☐

To the best of my knowledge the above medical history I believe to be true and correct.

Signature ____________

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