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 _____

603-882-9881 / 505 West Hollis Street / Suite 202 / Nashua, New Hampshire 03062-1350 / Fax: 603-881-4889