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p 207.621.0033 f 207.622.0337

325 Kennedy Memorial Dr. #C

• Waterville ME 04901 • p 207.873.5333 f 207.873.0572

<u>Preliminary Health Histo</u>	ory Form	
• First Name	•Middle Name	•Last Name
•Birthdate	•Gender M F	
•If the patient is a mino	or, parents' or guardians' name	
Emergency Contact Inf	ormation	
•Name of the nearest r	elative <u>not</u> living with you	
•Complete Address		
•Home Phone •Cell Pho		one
Medical History		
•Physician	Phone Number	•Date of last visit
• Are you taking any me	edication (if yes, which ones)?	
Please check any of the	e following that you have had o	or currently have:
□Abnormal bleeding/Hemophilia		□Heart Murmur
□ADD/ADHD		□Hepatitis/Liver Problems
□Asthma/Hay Fever		□Herpes
□Autism		□High Blood Pressure
□Congenital Heart Defect		□HIV/AIDs
□Diabetes		□Prolonged Bleeding
□Epilepsy		□Radiation/Chemotherapy
□Heart Problems		□Tumor/Cancer
Are there any medical	conditions we have not discuss	ed that you feel we should be aware of?
•General Dentist•Date		e of Last Visit
•What concerns you m	ost about your teeth?	
•Are you presently in a	ny dental pain?	
•Have you ever seen a	n orthodontist?	
• Are you concerned a	bout any iaw issues (for exampl	le: clicking, popping, pain, tension)?