Marina Bay Dental Associates P.C.
308 Victory Road
Quincy, MA 02171
Phone: 617-479-8080 Fax: 617-479-8189

Patient name_____
Last First Date of Birth

Physician's name _____

Physician's Address _____

Physician's Phone # _____

Are you under a physician's care? (other than yearly checkups) ☐Yes ☐No

Since when _____ Why _____

1. When was your last physical exam? _____
2. Are you taking any medications or substances? ☐Yes ☐No explain_____
3. Are you allergic to any medications or substances? ☐Yes ☐No explain_____
4. Do you have any other allergies? ☐Yes ☐No
5. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ☐Yes ☐No explain_____
6. Are you sensitive to any metals or latex? ☐Yes ☐No
7. Are you pregnant or suspect you may be? ☐Yes ☐No
8. Do you use birth control medication? ☐Yes ☐No
9. Have you been treated for or have been told you have heart disease? ☐Yes ☐No
10. Do you have a pacemaker or an artificial heart valve implant? ☐Yes ☐No
11. Any history of rheumatic fever or heart murmurs? ☐Yes ☐No
12. Have you ever had a serious illness or major surgery? ☐Yes ☐No
    If so, explain _____
13. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ☐Yes ☐No
14. Do you have inflammatory disease such as arthritis or rheumatism? ☐Yes ☐No
15. Do you have any artificial joints or prosthesis? ☐Yes ☐No
16. Do you have any blood disorder such as anemia, leukemia, etc? ☐Yes ☐No
17. Have you ever bled excessively after being cut or injured? ☐Yes ☐No
18. Do you have any stomach, kidney or liver problems? ☐Yes ☐No
19. Are you diabetic? ☐Yes ☐No
20. Do you have asthma? ☐Yes ☐No
21. Do you have epilepsy or seizure disorders? ☐Yes ☐No
22. Have you tested positive for HIV? ☐Yes ☐No
23. Do you have AIDS? ☐Yes ☐No
24. Have you have or had tested positive for Hepatitis? ☐Yes ☐No
25. Do you have or had T.B.? ☐Yes ☐No
26. Do you smoke, chew, use snuff or any other form of tobacco? ☐Yes ☐No how often_____
27. Do you consume alcoholic beverages? ☐Yes ☐No
28. Have you had psychiatric treatment? ☐Yes ☐No explain_____
29. Do you have any disease, condition, or problem not listed? ☐Yes ☐No
    If so, explain _____
30. Is there anything else we should know about your health that we have not covered In this form? _____ ☐Yes ☐No

I Certify that the above information is Complete and Accurate
Patient/Guardian Signature _____ Date _____

Dentist Signature _____Date _____

MEDICAL HISTORY