



GALLANT DENTAL CARE

33 Clinton Rd. Suite 106 ~ West Caldwell, NJ 07006
 Phone: 973.227.9211 ~ Fax: 973.227.9338

Medical/Dental History

Date _____
 Name _____ Cell Phone# _____
 Address _____ Home Phone# _____
 City _____ State _____ Zip Code _____
 Social Security# _____ - _____ - _____ Date of Birth _____ Sex M F
 Height _____ Weight _____ Single _ Married _ Name of Spouse _____
 Person to contact in an emergency _____ Phone _____

Employer _____ Phone _____
 Address _____
 City _____ State _____ Zip _____

Dental Insurance (primary) _____
 Group # _____ ID# _____
 Dental Insurance (secondary) _____
 Group # _____ ID# _____

Referred By _____

If you are completing this form for another person what is your relationship? _____

1. Are you in good health? _____
2. Have there been any changes in your health within the past year? _____
3. Are you now under the care of a physician? _____ Why? _____
4. Physician: name, phone _____
5. Any serious illness or hospitalizations within past 5 years? _____
6. Please list all medications that you take _____

7. Have you ever had any of the following?

Damaged Heart Valve	Y	N	Heart Murmur	Y	N
Rheumatic Fever	Y	N	Cardiovascular Prob.	Y	N
High Blood Pressure	Y	N	Heart Attack	Y	N
Allergies	Y	N	Asthma	Y	N
Seizures or fainting	Y	N	Diabetes	Y	N
Sexually transmitted disease	Y	N	AIDS or HIV	Y	N
Thyroid problem	Y	N	Breathing problem	Y	N
Persistent cough	Y	N	Swollen glands	Y	N
Cancer	Y	N	Psychological prob.	Y	N

Abnormal Bleeding Y N Blood transfusion Y N
Anemia Y N Low Blood Pressure Y N

8. Are you allergic to any medications? _____
9. Have you had any serious problems with any dental treatment? _____
10. Is there any problem not listed that you think is important to discuss? _____

Women

1. Are you pregnant? _____
2. Are you presently nursing? _____
3. Do you take birth control pills? _____

Dental History

1. Do your gums bleed? _____
2. Do you have bad breath or a stale taste in your mouth? _____
3. Do you have any loose teeth? _____
4. Are there cosmetic improvements that you would like to make? _____
5. Do you want to be asleep for your dental treatment? _____
6. Do you have difficulty chewing? _____
7. Have you ever been diagnosed with gum disease? _____
8. Do you have any particular concerns about your dental health? _____

Please describe in detail your primary dental concerns and questions _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the dentist, or any other member of the dental staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Guardian

Date