DATE:_____

GOOD SAMARITAN CARE DENTAL CLINIC Phone: (417) 934-6500

PATIENT HISTORY FORM ***(Please print)***

Last Name:_____ **First Name:** _____ **Middle Initial:** ___

Date of Birth:_____**SS#:**_____**Sex: (Male or Female:** _____

Address:_____**County:**_____

City, State, Zip:_____

Home Phone:_____**Work or Cell Phone:**_____

DENTAL COVERAGE? Yes No (INSURANCE, MEDICARE OR MEDICAID?_____**)**

CURRENT MEDICATIONS	**DRUG ALLERGIES**
_____	_____
_____	_____
_____	_____

Does Your Medical History Include Any of the Following Conditions?
(*circle Y for yes, N for no)*

Y/N 1. Have you ever had Diabetes?
Y/N 2. Have you ever had Hepatitis?
Y/N 3. Have you ever had Rheumatic Fever?
Y/N 4. Have you ever had any problems with a Heart Valve?
Y/N 5. Have you ever had a Hip or Joint Replacement?
Y/N 6. Have you ever been diagnosed as HIV positive?
Y/N 7. Have you ever had an allergic reaction to any drugs?
Y/N 8. Have you ever had an allergic reaction to Novacaine?
Y/N 9. Have you ever had an allergic reaction to Lidocaine?
Y/N 10. (Women) Are you taking birth control pills at this time?
Y/N 11. Are you under the care of a Physician at this time?
Y/N 12. Are you allergic to penicillin?
Y/N 13. High Blood Pressure?
Y/N 14. Do you have Heart Disease or a Heart Murmur?
Y/N 15. Have you ever had Cancer, Chemotherapy, or IV Bisphosphonate Treatments?
Y/N 16. Are you taking anticoagulants?
Y/N 17. Have you ever had excessive bleeding problems?
Y/N 18. Have you ever had Kidney Problems?
Y/N 19. Have you ever had Venereal Disease?
Y/N 20. (Women) Are you pregnant?
Y/N 21. (Other)_____

- -O-P-T-I-O-N-A-L- -

Do you have a need you would like to discuss with a minister? YES_____
If so, please sign below & indicate your religious preference.
(ex: no preference, Assembly of God, Baptist, Catholic, Methodist, Nazarene, Presbyterian, etc.)

_____

Signature *Religious Preference*