Tad Morgan, D.D.S.

Family and Restorative Dentistry
17789 FM 344 West · Flint, Texas 75762
Telephone: 903.825.1112 Fax: 903.825.1115

PRELIMINARY HEALTH HISTORY FORM

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ DOB: _____

WORK PHONE: _____ CELL PHONE: _____

EMPLOYMENT: _____

SOCIAL SECURITY NUMBER: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (circle one)

TV RADIO DIRECT MAIL FRIEND/FAMILY OTHER

WHAT IS YOUR EMAIL ADDRESS? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

_____

ARE YOU ALLERGIC TO LATEX? _____

DO YOU HAVE, OR HAVE YOU HAD HEART TROUBLE, HEART MURMUR, RHEUMATIC FEVER, VALVE DISEASE/REPLACEMENT, OR MITRAL VALVE PROLAPSE? (OR ANY OTHER CONDITION REQUIRING PREMEDICATION WITH ANTIBIOTICS? _____

_____

WHEN WAS THE APPROXIMATE DATE OF YOUR LAST DENTAL CLEANING? _____

NAME OF CURRENT DENTIST: _____

WHAT DON’T YOU LIKE ABOUT YOUR TEETH?

___ CROWDING/CROOKED TEETH

___ SPACES

___ TOOTH SHAPE

___ TOOTH SIZE

___ GUMMY SMILE

___ UNDERBITE

___ TEETH ARE DIFFERENT COLORS

___ OTHER _____

___ JAW JOINT PAIN

___ MISSING TEETH

___ DARK TEETH

___ UGLY OLD CROWNS

___ SPEECH PROBLEMS

___ OVERBITE

___ FACIAL PROFILE

I AM INTERESTED IN:

___ 6 MONTH BRACES

___ TEETH WHITENING

___ VENEERS

___ OTHER _____

IS THERE ANYTHING YOU WOULD LIKE THE DENTIST TO KNOW?

_____

_____

_____