Dibling Dental

317 Route 9 South (Alexander Plaza)
Manalapan, NJ 07726 I Ph: 732-780-6426 I Fax: 732-409-3514

Medical History

Physician's name_____ Date of last physical exam_____
Birthdates_____ Age_____

Do you have or have you had any of the following. Please indicate with check marks.

___ Any Heart problems	___ Allergies to medicines	___Diabetes	___Sinus Problems
___ High Blood pressure	___drugs	___Hepatitis	___Stroke
___Low blood pressure	___Allergies to:	___Herpes	___Typhoid Fever
___Circulatory	_____	___ Malignancies	___Tonsillitis
___Nervous Problems	_____	___Measles	___Tuberculosis
___Radiation	_____	___Mumps	___ Ulcer
___Excessive Bleeding	___Anemia	___Psychotic care	___Venereal Disease
___HIV/AIDS	___ Arthritis	___Rheumatic fever	___other
___ Allergies to anesthetics	___ Asthma	___Scarlet Fever	

Are you pregnant_____ Blood Pressure S____/D____/_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

_____

_____

_____

_____

Do you now have or have you had any of the following habits:

Thumb sucking____ Finger Sucking_____ Cheek or tongue chewing____ Pens_____
Lips____ Fingernails___Tobacco use_____ Alcohol use_____

Do you have any fear of having dentistry done_____

If Yes, why_____

How do you feel about your teeth_____

How do you feel about dentures_____

Do you want to avoid the dental discomfort you may have experienced in the past

_____

Do you want to avoid dentures _____

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Do you want to have a pleasant breath _____

Do you want to know how you can keep the natural teeth you still have

_____

If you have children, do you want to learn how they may keep their natural teeth for a lifetime without discomfort

Date_____

Your Signature _____