Dental Clinical History

File # _____
Date: _____

Patient Name:

_____
Paternal Surname Maternal Surname Names

Date of Birth: ___/___/_____ Place of Birth : _____

Sex: _____ Age:_____ Marital Status_____ Occupation:_____

Education:_____ Religion:_____ Sexual Preference:_____

Address:_____

Home Phone: _____ Cellular:_____ Office: _____

E-mail Address_____

Name and number of a close relative:_____

Type of interrogation:_____ Direct:_____ Indirect:____ Name:_____

Name and kinship of the patient's legal responsibility.

_____

ALERT

Allergies, disease, limiting capabilities, medications:

_____

_____

_____

Reason for the consultation:

_____

_____

_____

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