PLEASE PRINT THE FOLLOWING INFORMATION

Patient_____Birthdate_____/_____/_____

Last Name First Name Middle Name

Social Security No._____ Full Name of Husband or Wife_____

Residence Address_____Phone_____

Street No. Street City Zip

Business Address_____Phone_____

Street No. Street City Zip

Employer_____Occupation_____

Spouse Employed By _____Occupation_____

Dental Insurance Carrier_____Dental Plan No._____

Date of Last Dental Treatment_____Where_____

Date of Last Full Mouth X-Rays_____Referred By_____

What Is Your Dental Problem?_____

E-Mail Address_____

HEALTH HISTORY

Physician's Name_____Date of Last Visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Anemia	☐Yes ☐No	Glucerna	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Headaches	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Problems	☐Yes ☐No	Slightness of Breath	☐Yes ☐No
Asthma	☐Yes ☐No	Hepatitis Type____	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Back Problems	☐Yes ☐No	Herpes	☐Yes ☐No	Skin Rash	☐Yes ☐No
Bleeding abnormally, with		High Blood Pressure	☐Yes ☐No	Special Diet	☐Yes ☐No
extractions of surgery	☐Yes ☐No	HIV Positive	☐Yes ☐No	Stroke	☐Yes ☐No
Blood Disease	☐Yes ☐No	Jaundice	☐Yes ☐No	Swelling of Feet	
Cancer	☐Yes ☐No	Jaw Pain	☐Yes ☐No	or Ankle	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tumor or growth	☐ ☐
Cortisone Treatments	☐Yes ☐No	Nervous Problems	☐Yes ☐No	on head or neck	☐Yes ☐No
Cough, persistent or bloody	☐Yes ☐No	Pacemaker	☐Yes ☐No	Ulcer	☐Yes ☐No
Diabetes	☐Yes ☐No	Women		Weight Loss.	
Emphysema	☐Yes ☐No	Are you pregnant?	☐Yes ☐No	unexplained	☐Yes ☐No
Do you wear contact lenses?	☐Yes ☐No	Due Date_____	☐Yes ☐No		
Epilepsy	☐Yes ☐No	Are you nursing?	☐Yes ☐No		

MEDICATIONS	ALLERGEIES
List medications you are currently taking:_____	☐ Aspirin ☐ Penicillin
_____	☐ Barbiturates (sleeping pills) ☐ Sulfa
_____	☐ Codeine ☐ Other_____
Have you ever taken Fen-Phen? ☐ Yes ☐ No	☐ Iodine _____
Have you ever taken Redux? ☐ Yes ☐ No	☐ Latex _____
Have you ever taken Pondimin? ☐ Yes ☐ No	☐ Local Anesthetic _____

DATE	PATIENT'S/PARENTS SIGNATURE	P/HP	DOCTOR'S SIGNIATURE

UPDATES

(To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____If so, what?_____

Patient's Signature_____Date:_____

Doctor's Signature_____Date:_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____If so, what?_____

Patient's Signature_____Date:_____

Doctor's Signature_____Date:_____

(To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____If so, what?_____

Patient's Signature_____Date:_____

Doctor's Signature_____Date:_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____If so, what?_____

Patient's Signature_____Date:_____

Doctor's Signature_____Date:_____