Name_____ Social Security #_____ Birth Date_____

Address_____ City_____ Zip Code_____

Spouse's Name_____ Social Security #_____ Birth Date_____

Your Place of Employment_____ Occupation_____

Spouse's Place of Employment_____ Occupation_____

Home Phone_____ Business Phone_____ Cell Phone_____

Dental Insurance Co._____ Grp#_____ Address_____ Ins Phone #_____

Physician_____ Referring Dentist_____

Person Financially Responsible_____ Emergency Contact_____ Phone_____

Email Address_____

Circle yes or no for each of the following questions. All answers are confidential.

Y N Are you in good health today?
Y N Have there been any changes in your general health within the past 5 years?
Y N Are you now under the care of a physician?
Y N If so, what is the condition being treated?_____
Y N Have you been hospitalized for a serious illness or operation?_____
Y N If so, explain:_____
Y N Are you taking any medications now?List:_____
Y N Are you taking aspirins?
Y N Have you ever taken Fen-Phen or Redux?

Are you allergic to any medications or have you had any adverse reaction to any of the following? Y N
Please check and explain.

Local dental anesthestic (novacaine)_____ Tetracycline_____
Epinephrine_____ Aspirin_____
Penicillin_____ Codeine_____
Erythromycin_____ Any other medication_____
Latex_____

Do you have or have you ever had any of the following condition? Please circle Yes or No

Y N	Heart Attack (MI)	Y N	Hip or joint replacements*	Y N	Radiation therapy
Y N	Angina (Chest Pain)	Y N	Breast or other implants*	Y N	Arthritis
Y N	Stroke	Y N	Renal Failure*	Y N	Thyroid Problem
Y N	High Blood Pressure	Y N	Diabetes*	Y N	Epilepsy
Y N	Arrhythmia (irrg hrt beat)	Y N	Liver Disorders	Y N	Sinus Problems
Y N	Congestive Heart Failure	Y N	Bleeding Disorders	Y N	Hepatitis
Y N	Bypass Surgery*	Y N	Anemia	Y N	Tuberculosis
Y N	Heart Murmur*	Y N	Kidney Disorders	Y N	Herpes
Y N	Rheumatic Fever*	Y N	Lung Problems	Y N	AIDS
Y N	Mitral Valve Prolapse*	Y N	Asthma	Y N	AIDS related illness
Y N	Aortic Stenosis*	Y N	Adrenal Insufficiency	Y N	AIDS antibodies
Y N	Prosthetic Heart Valve*	Y N	Psychological Disorder	Y N	Ulcers
Y N	Other Heart Valve Prob.*	Y N	Cancer	Y N	Other_____

*Please explain all conditions checked above in terms of current status, dates condition affected you and seriousness of disorder as it affects your current health._____

_____

Women: Are you pregnant at this time? Y N If yes, due date_____

We strive to make every visit as comfortable as possible. Please let us know if there is anything specific we can do to make you feel more at ease:_____

Do you have (Please circle) Y N Sensitive Teeth Y N Grit, Grind or clinch teeth
Y N Bleeding Gums Y N Difficulty opening mouth
Y N Frequent canker/cold sores or chewing
Y N History of gum disease, when_____

If prescriptions are needed, what pharmacy would you like us to contact?_____

I certify that I have read and answered the above questions truthfully and to the best of my knowledge.

Signature_____ Date_____

Doctor's Signature_____ Date_____