Your full name ____________________ Email ____________________

Birthdate ____________ Weight ____________ Height ____________ Marital Status ____________

Residence Address ____________ City ____________ Apt. # ______ Zip Code ____________

Home Phone ____________ Work Phone ____________ Cell ____________

Employed By ____________________ Occupation ____________________

Social Security # ____________________ Driver's License # ____________________

Please answer the following as completely as possible:

This is requested in order that the doctor may thoroughly diagnose your condition and it is of course confidential.

Reason for this visit? ____________________

Have you had any previous dental experiences worth noting? ____________________

Dentist's Name ____________________ Referred by (we like to say "Thank you") ____________________

Physician's Name ____________________ Physician's Phone ____________________

Name of your Dental Insurance Company ____________________

HEALTH HISTORY

	Yes	No
Are you in good health? ____________	☐	☐
Are you now under the care of a physician? ____________	☐	☐
Are you taking any drugs, medicines, or pills? ____________	☐	☐
Please List: ____________		
Have you had excessive bleeding requiring special treatment? ____________	☐	☐
Do you have any known drug reactions? ____________	☐	☐
Are you allergic to or have you reacted adversely to:		
Local anesthetics ("Novacaine")? ____________	☐	☐
Penicillin or other antibiotics? ____________	☐	☐
Sulfa Drugs? ____________	☐	☐
Barbiturates, Sedatives, or Sleeping Pills? ____________	☐	☐
Aspirin? ____________	☐	☐
Other Drugs? ____________	☐	☐

Have you ever had any of the following conditions: (Please Check)

- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ High or Low Blood Pressure
- ☐ Liver/ Kidney Disorders (Hepatitis)
- ☐ Respiratory Disorders (Tuberculosis)
- ☐ Anemia
- ☐ Thyroid
- ☐ Asthma
- ☐ Sinusitis
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Stomach Ulcer
- ☐ Heart Murmur/Mitro Valve Prolapse
- ☐ Aids/HIV
- ☐ Hysterectomy
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Hip/Knee Replacements
- ☐ Radiation Treatment
- ☐ Are you required to premedicate?

Do you smoke? ____________ How many packs/day? ____________

	Yes	No
Have you had any other serious illnesses or operations? ____________	☐	☐
Has anyone in your family ever had Diabetes? ____________	☐	☐
Have you had psychiatric therapy? ____________	☐	☐
Have you had periodontal treatment? ____________	☐	☐
Have you had "trenchmouth"? (Anug) ____________	☐	☐
Have you had orthodontic therapy? ____________	☐	☐
Do you clench or grind your teeth? ____________	☐	☐
Women: Are you pregnant? ____________	☐	☐
Are you taking birth control pills? ____________	☐	☐
Is there anything else we should be aware of? ____________	☐	☐

____

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definitive arrangement of appointments and fees. Once you have made an appointment, remember this time is reserved for you – therefore, AT LEAST 48 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY. OTHERWISE USUAL FEE CHARGE WILL BE MADE.

I ACCEPT RESPONSIBILITY

____________________ Reviewed by   Date

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