

Female Male Married Single Divorced Widower Widow

Patient's Name _____ Date of Birth _____ Soc Sec # _____ DL# _____

If a Child, Parent's Name _____ Parent's Date of Birth _____ Parent's Soc Sec # _____

Mailing Address _____ City _____ State _____ Zip _____

Residence Phone _____ Business Phone _____ Cell Phone _____ Other Contact Number _____

Patient or Parent Employed by _____ Business Address _____ Spouse Employed by _____ How Long? _____

Name of Spouse _____ Spouse Soc Sec # _____ Spouse Date of Birth _____

Name of Dental Insurance Company _____ Insurance Co Phone # _____ Name of Person Insured _____ Insured Soc Sec # _____

Insured Date of Birth _____ Insurance Co Phone # _____ Group # _____ Policy # _____ ID # _____

**If no dental insurance, payment is due at time services are rendered.*

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO	YES	NO	YES	NO	YES	NO
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	Prescribed Diet Drugs	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Fainting / Dizzy Spells	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>
Heart Disease/Attack	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Tumor	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S. - HIV positive	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	X-Ray / Cobalt Treatment	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B(Serum)	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Artificial Joints, Implants	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	(Syphilis, Gonorrhea, etc)	<input type="checkbox"/>

Date of Last Medical Exam _____ Name of Physician _____ Are you under the care of a Physician now? _____

Are you Taking Medication? _____ If yes, What? _____ Are You, or Could You be Pregnant? _____

Are you allergic to or have you reacted adversely to any of the following medications: (please circle)

Aspirin Percodan Erythromycin Darvon Local Anesthetic Valium Nitrous Oxide Codeine Penicillin Latex Other

Any Other Physical Conditions _____ Emergency Contact _____ Phone # _____

Last Dental Visit _____ Last Dental X-rays _____ Are Your Teeth sensitive to Hot, Cold or Pressure? _____ Ever Been Diagnosed with Gum Disease? _____

Do You, or Have You Used Tobacco Products? _____ Recreational Drugs? _____ Alcohol? _____ Referred by _____

Signature _____ Date _____ Email Address _____