Patient Information
(Please Print)

Name _____ Birthdate _____
First Last

Address _____ City _____ State _____ Zip _____

Patients Employer and Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Whom may we thank for referring you? _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security Number _____ Work Phone _____

Employer Name and Address _____

Insurance Company _____ Group # _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note additional questions concerning your health may be asked.

Are you in good health? Yes No

Any change in your general health within the past year Yes No

Are you now under the care of a physician Yes No

If so, what is the condition being treated _____

The name and address of my physician(s) _____

_____

Are you taking any medication(s) including any non-prescriptive medication (aspirin, motrin-daily) Yes No

If so, what medications are you taking _____

_____

_____

Do you have or have you had any of the following diseases or problems:

- Damaged heart valves or Heart Murmur Yes No
- In born heart defect Yes No
- Rheumatic heart disease Yes No
- Cardiovascular disease Yes No
- Heart trouble, Heart attack, Angina or Stroke Yes No
- High blood pressure Yes No

Do you have a cardiac pacemaker Yes No

- Sinus Trouble Yes No
- Fainting spells or seizures Yes No
- Diabetes Yes No
- Hepatitis Yes No
- AIDS or HIV infection Yes No
- Thyroid Problems Yes No
- Artificial Joints Yes No
- Respiratory problems, Emphysema, or Bronchitis Yes No
- Kidney Trouble Yes No
- Tuberculosis Yes No
- Sexually transmitted diseases Yes No
- Epilepsy Yes No
- Other neurological diseases Yes No
- Cancer Yes No

Have you had abnormal bleeding Yes No

Have you ever required a blood transfusion Yes No

Do you have any blood disorder such as anemia Yes No

Have you had treatment for a tumor or growth Yes No

Are you allergic or have you had a reaction to:

- Local anesthetics Yes No
- Penicillin or other antibiotics _____ Yes No
- Sulfa drugs Yes No
- Codeine or other narcotics Yes No
- Other allergies _____

Have you ever had any serious trouble associated with any previous dental treatment Yes No

Do you have any disease, condition or problem not listed above _____ Yes No

Women

- Are you pregnant or nursing Yes No
- Are you taking birth control pills Yes No

Brief Dental History or Complaint _____

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____