Answers to all Questions are for Office Use Only and are Strictly Confidential.

Last Name _____ First Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Preferred Phone ( ) _____

E-mail _____ Social Security No. _____

Birth Date _____ Patient's Employer _____

Occupation _____ Business Phone ( ) _____

Referring Dentist _____ Patient's Physician _____

Do you have dental insurance? YES or NO *(Circle One)* If yes, what company? _____

Marital Status _____

Emergency Contact:

Name _____ Relationship _____ Phone ( ) _____

Mark an "X" in the box next to any of the following illnesses you have now or have ever had:

- ❑ Diabetes
- ❑ Hives or rashes
- ❑ Emphysema
- ❑ Liver Disease
- ❑ Depression
- ❑ Rheumatic Fever
- ❑ Allergies
- ❑ Tuberculosis
- ❑ Osteoporosis
- ❑ Heart Trouble
- ❑ Hepatitis
- ❑ Venereal Disease
- ❑ Anemia or Blood Diseases
- ❑ Stomach Problems
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Other Infectious Disease (excluding childhood diseases)
- ❑ Cancer Type:_____

Have you ever had any of the following dental therapy?

- ❑ Bite Adjustment
- ❑ Teeth Straightened
- ❑ Treatment of gum tissues

Mark an "X" in the box next to any medicines that you are now taking or that you have had a reaction to:

	Now Taking	Had Reaction		Now Taking	Had Reaction
Penicillin	❑	❑	Cold Tablets	❑	❑
Sulfa	❑	❑	Diet Pills	❑	❑
Other Antibiotics	❑	❑	Anesthetics	❑	❑
Aspirin	❑	❑	Tranquilizer	❑	❑
Codeine	❑	❑	Cholesterol	❑	❑
Demerol	❑	❑	**List any other medicines taken**		
Sedatives	❑	❑	**including Over the Counter**		
Stimulants	❑	❑	_____	❑	❑
Cortisone	❑	❑	_____	❑	❑
Heart Medication	❑	❑	_____	❑	❑
Antacids	❑	❑	_____	❑	❑

Please Circle Your Answers:

YES NO Are you troubled with stiff or painful muscles or joints?

YES NO Are you handicapped in any way?

YES NO Do you have skin problems?

YES NO Do you have trouble stopping even a small cut from bleeding?

YES NO Have you or any member of you family ever had bleeding problems?

YES NO Have you ever had your tonsils out? If so, what year? _____

Did you have prolonged bleeding after surgery? YES NO

YES NO Do your ever faint or feel faint?

YES NO Have you ever had convulsions?

YES NO Do you consider yourself a nervous individual?

YES NO Are you disturbed by any work or family problems?

YES NO Have you gained or lost much weight recently? Present weight _____ Present height _____

Continued on back...

YES NO Do you always seem to be hungry?

YES NO Do you awake with unusual thirst or need to urinate?

YES NO Do you or did you smoke or use smokeless tobacco?

If YES, how much? _____ How long? _____ How long since quitting? _____

YES NO Do you take two or more alcoholic drinks a day?

YES NO Do you have a prosthetic joint? If YES, date? _____ Pre-medication required? YES NO

YES NO Do you easily become nauseated?

YES NO Do you have headaches more than one a week?

YES NO Are you bothered by coughing spells?

YES NO Have you ever been bothered by a thumping or racing heart?

YES NO Have you ever had a heart attack or stroke?

YES NO Pacemaker or artificial valve?

YES NO Does every little effort leave you short of breath?

YES NO Do you ever get pains, angina or tightness in your chest?

YES NO Have you ever been told that you have a heart murmur?

YES NO Have you ever received radiation therapy? Chemotherapy?

YES NO Have you ever been under a physician's care within the past year?

If so, for what reason? _____

YES NO Have you ever been hospitalized for any serious medical illness or operation?

If so, for what reason? _____

_____

Did you receive a blood transfusion? YES NO

For Women Only

YES NO Have you ever or are you presently taking a form of hormonal birth control or hormonal replacement therapy?

YES NO Have you gone through or are you presently going through menopause?

YES NO Are you (or could you be) pregnant at the present time?

I certify that the above health history information is accurate.

SIGNATURE _____ DATE _____

I authorize release of any information relating to insurance claims. I understand that I am responsible for all costs of dental treatment, regardless of insurance coverage.

SIGNATURE _____ DATE _____