

WELCOME

ABOUT YOU

Today's Date: _____

Name: _____ Nickname: _____ Male Female

Home Address: _____

City State Zip

Home Phone #:(____) _____

Cell Phone #:(____) _____

Emergency Contact Person & #:

Work Phone #:(____) _____

Birthdate: ____/____/____ Age: ____ Social Security #: _____

Single Married Partnered Divorced Widowed

Spouse's Name: _____ Birthdate: ____/____/____ SSN #: _____

Employer: _____ Work Phone #:(____) _____

Whom may we thank for referring you: _____

Other family members seen by us: _____

Employer: _____

Occupation: _____

Insurance Company: _____ Policy Holder's Name: _____

Insurance Address: _____

City State Zip

Insurance Phone #:(____) _____ Group (Plan or Policy #): _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Personal Physician: _____ Phone #: (____) _____

Date of last visit: ____/____/____ Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No Please explain: _____

Have you ever been hospitalized or had a major operation? Yes No Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one: _____

Have you ever taken Phen-Fen (Redux or Pondimin)? Yes No If yes, when? _____

For Women: Pregnant: Yes No Taking Oral Contraceptives: Yes No Nursing: Yes No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Codeine	Y N Jewelry/Metals	Y N Sulfa Drugs
Y N Barbiturates	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other _____

Do you or have you experienced the following?

Y N AIDS/HIV Positive	Y N Cortisone Medicine	Y N Hemophilia	Y N Renal Dialysis
Y N Alzheimer's Disease	Y N Diabetes	Y N Hepatitis A	Y N Rheumatic Fever
Y N Anaphylaxis	Y N Drug Addiction	Y N Hepatitis B or C	Y N Rheumatism
Y N Anemia	Y N Easily Winded	Y N Herpes	Y N Scarlet Fever
Y N Angina	Y N Emphysema	Y N High Blood Pressure	Y N Shingles
Y N Arthritis/Gout	Y N Epilepsy or Seizures	Y N Hives or Rash	Y N Sickle Cell Disease
Y N Artificial Heart Valve	Y N Excessive Bleeding	Y N Hypoglycemia	Y N Sinus Trouble
Y N Artificial Joint	Y N Excessive Thirst	Y N Irregular Heartbeat	Y N Spina Bifida
Y N Asthma	Y N Fainting/Dizziness	Y N Kidney Problems	Y N Stomach/Intestinal
Y N Blood Disease	Y N Frequent Cough	Y N Leukemia	Y N Stroke
Y N Blood Transfusion	Y N Frequent Diarrhea	Y N Liver Disease	Y N Swelling of Limbs
Y N Breathing Problems	Y N Frequent Headaches	Y N Low Blood Pressure	Y N Thyroid Disease
Y N Bruise Easily	Y N Genital Herpes	Y N Lung Disease	Y N Tonsillitis
Y N Cancer	Y N Glaucoma	Y N Mitral Valve Prolapse	Y N Tuberculosis
Y N Chemotherapy	Y N Hay Fever	Y N Pain in Jaw Joints	Y N Tumors or Growths
Y N Chest Pains	Y N Heart Attack	Y N Parathyroid Disease	Y N Ulcers
Y N Cold Sore/Fever Blisters	Y N Heart Murmur	Y N Psychiatric Care	Y N Venereal Disease
Y N Congenital Heart Disorder	Y N Heart Pace Maker	Y N Radiation Therapy	Y N Yellow Jaundice
Y N Convulsions	Y N Heart Trouble/Disease	Y N Recent Weight Loss	

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN: _____ DATE: _____