PATIENT
Mr. _____ Date _____
Mrs.
Miss _____ Birthdate _____ Age _____ Soc. Sec. No. _____

Home Address _____ City _____ Zip _____ Phone No. _____
Person Financially
Responsible _____ Relationship to you _____ Business Phone _____
Primary
Insurance _____ Subscriber name _____ Birthdate _____ SS# _____

Group & Plan Number _____ Employer _____ Phone No. _____
Secondary
Insurance _____ Subscriber name _____ Birthdate _____ SS# _____

Group & Plan Number _____ Employer _____ Phone No. _____

Referred to our office by: _____ When was your last dental exam? _____

When was your last cleaning? _____

Medical History

Physician _____ Phone No. _____

Are you taking any medication, pills or drugs? _____ If so, please list _____

1. Are you having pain or discomfort at this time? ..... ❑ YES ❑ NO
2. Do you feel very nervous about having dental treatment? ..... ❑ YES ❑ NO
3. Have you ever had a bad experience in the dental office? ..... ❑ YES ❑ NO
4. Have you been a patient in the hospital during the past two years? ..... ❑ YES ❑ NO
5. Have you been under the care of a medical doctor during the past two years? ..... ❑ YES ❑ NO
6. Have you used Fen-phen? ..... ❑ YES ❑ NO
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by sulfa, penicillin, aspirin, codeine, or any drugs or medications? ..... ❑ YES ❑ NO
8. Have you ever had any excessive bleeding requiring special treatment? ..... ❑ YES ❑ NO
9. Check any of the following which you have had or have at present:

❑ Heart Failure	❑ Stroke	❑ Chemotherapy (Cancer, Leukemia)	❑ Drug Addiction
❑ Heart Disease or Attack	❑ Kidney Trouble	❑ Arthritis	❑ Hemophilia
❑ Angina Pectoris	❑ Ulcers	❑ Rheumatism	❑ Venereal Disease (Syphilis Gonorrhea)
❑ High Blood Pressure	❑ Emphysema	❑ Cortisone Medicine	❑ Cold Sores
❑ Heart Murmur	❑ Cough	❑ Glaucoma	❑ Genital Herpes
❑ Rheumatic Fever	❑ Tuberculosis (TB)	❑ Pain in Jaw Joints	❑ Epilepsy or Seizures
❑ Congenital Heart Lesions	❑ Asthma	❑ AIDS or HIV	❑ Fainting or Dizzy Spells
❑ Scarlet Fever	❑ Sleep Apnea	❑ Hepatitis	❑ Latex Allergy
❑ Artificial Heart Valve	❑ Sinus Trouble	❑ Alcoholism	❑ Psychiatric Treatment
❑ Heart Pacemaker	❑ Allergies or Hives	❑ Yellow Jaundice	❑ Bruise Easily
❑ Artificial Joint	❑ Thyroid Disease	❑ Blood Transfusion	❑ Diabetes
❑ Anemia	❑ X-ray or Radiation Treatment		❑ Sulfite Allergy
			❑ Implants

10. Have you lost or gained more than 10 pounds in the past year? ..... ❑ YES ❑ NO
11. Do you ever wake up from sleep short of breath? ..... ❑ YES ❑ NO
12. Are you on a special diet? ..... ❑ YES ❑ NO
13. Has your medical doctor ever said you have a cancer or tumor? ..... ❑ YES ❑ NO
14. Do you have any disease, condition, or problem not listed? ..... ❑ YES ❑ NO
15. WOMEN: Are you pregnant now? ..... ❑ YES ❑ NO
    Are you practicing birth control? ..... ❑ YES ❑ NO
    Do you anticipate becoming pregnant? ..... ❑ YES ❑ NO
16. Relative whom we can contact in event of emergency (*not living at same household*)

Name _____ Phone _____
(Last) (First) (Middle)

Address _____
(Number and Street) (City) (State) (Zip)

I understand that my insurance is an agreement beteween my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

_____ Date

_____ Signature of Patient, Parent or Guardian