Personal/Medical History

Name________________________ I like to be called ________________ SS #________________

Address ____ Zip ________

Age_____ Birthdate__________ Sex: M F Home Ph. (______)____________ Bus. Ph. (______)____________

Email ______________________________________ Cell Phone (______)____________

Marital Status: Single____ Married____ Widowed____ Separated____ Divorced____

Whom may we thank for referring you?____

Employer ______________________________ Occupation______________________

Employer's Address ____ Zip ________

Physician________________ Address ________________ Phone (______)____________

In case of emergency please notify: Name________________ Phone (______)____________

What is your present health? ☐ Good ☐ Fair ☐ Poor Are you having pain or discomfort at this time? ☐ No ☐ Yes

Check any of the following which you have had or have at present

_ Heart Conditions
_ Heart Attack or Stroke
_ Heart Murmur
_ Chest Pains (Angina)
_ Heart Surgery
_ Artificial Heart Valve
_ Heart Pacemaker
_ High Blood Pressure
_ Rheumatic Fever
_ Anemia or Hemophilia
_ Bruise Easily
_ Shortness of Breath

_ Swelling of Ankles
_ Artificial Joint
_ Lung Disease
_ Emphysema
_ Tuberculosis (T.B.)
_ Asthma or Hay Fever
_ Skin Rashes or Hives
_ Kidney Trouble
_ Diabetes
_ Sickle Cell Disease
_ Liver Disease

_ Hepatitis B
_ Hepatitis C
_ Yellow Jaundice
_ Blood Transfusion
_ Thyroid Disease
_ Cortisone Medicine
_ Glaucoma
_ Arthritis or Rheumatism
_ Pain in Joints
_ Fainting or Dizzy Spells
_ Alcoholism

_ Drug Addiction
_ Cancer or Tumor
_ Radiation Therapy (x-ray Cocoa)
_ Chemotherapy (Cancer, Leukemia)
_ HIV Positive/AIDS
_ Venereal Disease
_ Genital Herpes
_ Cold Sores
_ Epilepsy or Seizures
_ Psychiatric Treatment

Do you have any diseases, conditions or problems not listed above? .... No Yes
If yes, please explain ____________________

Are you presently taking any prescription or over-the-counter medications or drugs? .... No Yes
If yes, list drugs ____________________

Are you allergic to any medicine, latex, nickel or other substances? .... No Yes
If yes, please list ____________________

Are you now or have you been under the care of a Medical doctor during the last two years? .... No Yes

Have you ever been hospitalized or had surgery? .... No Yes

Have you ever had prolonged or unusual bleeding? .... No Yes

Have you ever had complications or illness following dental treatment? .... No Yes

Have you ever had an injury or trauma to your face or jaw? .... No Yes

Do you smoke or use smokeless tobacco? .... No Yes

Are you nervous or concerned about having dental work done? .... No Yes

Women: Are you pregnant now? .... No Yes
Due Date____________________
Do you anticipate becoming pregnant?... No Yes

Dental treatment Desired (check)

☐ Check up ☐ Cleaning ☐ Cavities Restored
☐ Teeth Whitened ☐ Teeth Extracted ☐ Complete Dentures
☐ Teeth Straightened ☐ Missing Teeth Replaced
☐ Other ____________________

Best time for dental appointments:

	MON	TUE	WED	THUR	FRI
AM					
PM					

Comments:

To the best of my knowledge, all of the preceding answers are true and correct.

Signature________________________________ Date ____________