

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Heart Attack or Stroke | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Cancer or Tumor |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Radiation Therapy (x-ray Cocca) |
| <input type="checkbox"/> Chest Pains (Angina) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tuberculosis (T.B.) | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HIV Positive/AIDS |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Skin Rashes or Hives | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain in Joints | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Anemia or Hemophilia | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Shortness of Breath | | | |

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

Comments:

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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Check up | <input type="checkbox"/> Cleaning | <input type="checkbox"/> Cavities Restored |
| <input type="checkbox"/> Teeth Whitened | <input type="checkbox"/> Teeth Extracted | <input type="checkbox"/> Complete Dentures |
| <input type="checkbox"/> Teeth Straightened | <input type="checkbox"/> Missing Teeth Replaced | |
| <input type="checkbox"/> Other _____ | | |

Best time for dental appointments:

	MON	TUE	WED	THUR	FRI
AM					
PM					

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

Signature _____ Date _____