Dr. Mr.
Mrs. Ms. First Name______________ Last Name________________________________

Birth Date______________________ S.S.#_____________________________________

Home Address____
Street City State Zip Code

Home Phone____________________________ Business Phone_____________________________
Cell Phone/Beeper____

Emergency Contact Name /Relationship/Phone#
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Referred By____

Employer/Occupation____

Business Address____
Street City State Zip Code

Dental Insurance Carrier_______________________ Policy #______________________________

Medical Insurance Carrier______________________ Policy #______________________________

This Office Does Not Participate In Any Dental Insurance Plans

For the following, please circle "Yes" or "No". Your answers are for our information and will be considered confidential.

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

Heart Murmur	Yes No		Hepatitis	Yes No
Mitral Valve Prolapse	Yes No		Sinus Trouble	Yes No
Rheumatic Fever	Yes No		Diabetes	Yes No
Angina	Yes No		Glaucoma	Yes No
Arteriosclerosis	Yes No		Sexually Transmitted Disease	Yes No
High Blood Pressure	Yes No		Asthma	Yes No
Low Blood Pressure	Yes No		Urinary Infection	Yes No
Anemia	Yes No		Kidney Disease	Yes No
Bleeding Problems	Yes No		Ulcers	Yes No
Liver Disease	Yes No		Cancer	Yes No
Thyroid Disease	Yes No		Radiation Therapy	Yes No
Lung Disease (T.B.)	Yes No		Chemotherapy	Yes No

PLEASE ANSWER THE FOLLOWING QUESTIONS

1) Are you in good health? Yes No
2) Are you presently under the care of a physician? Yes No

If so, for what condition?

Date of last physical exam

3) Are you presently taking any drug or medicine? (include over the counter, vitamins, natural or herbal preparations, diet supplements) Yes No
If so, please list them :

5) Do you drink alcoholic beverages? Yes No
6) Do you use tobacco products? Yes No
7) Have you ever been tested for H.I.V.? Yes No

Results of test POSITIVE NEGATIVE

8) Do you have heart trouble or cardiovascular disease? Yes No
9) Do you have damaged or artificial heart valves? Yes No
10) Have you taken an Echocardiogram? Date of Exam? Yes No
11) Do you require antibiotic coverage for dental procedures? Yes No
12) Do you have an artificial hip or other prosthetic device? Yes No
13) Do you have a Cardiac Pacemaker? Yes No
14) Do you experience chest pain upon exertion? Yes No
15) Do you routinely take aspirin on a daily basis? Yes No
16) Do you have a hearing problem? Yes No
17) Are you Pregnant? Yes or No What Month? Nursing? Yes No
18) Are you taking Birth Control Pills? Yes No

PLEASE CIRCLE ANY OF THE FOLLOWING DRUGS TO WHICH YOU MAY BE ALLERGIC:

PENICILLIN—AMOXICILLIN—AUGMENTIN—ERYTHROMYCIN--BIAXIN

ZITHROMAX—CLINDAMYCIN—CIPRO—FLAGYL—SULFUR—TETRACYCLINE

ASPIRIN--IBUPROFEN (MOTRIN, ADVIL)--ALEVE (NAPROXEN)--

CODEINE—VICODIN (HYDROCODONE) & TYLENOL (ACETAMINOPHEN)

LOCAL ANESTHETIC—NOVOCAINE--ADRENALIN (EPINEPHRINE)

LATEX--SEASONAL ALLERGIES--OTHER ALLERGIES

Name, address and phone # of Physician

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NOTE: BOTH DOCTOR AND PATIENT ARE ENCOURAGED TO DISCUSS ANY AND ALL-RELEVANT PATIENT HEALTH ISSUES PRIOR TO TREATMENT.
I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ACTION THEY TAKE OR DO NOT TAKE BECAUSE OF ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

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PATIENT SIGNATURE/GUARDIAN DATE D.D.S. INITIALS

MEDICAL HISTORY UPDATE (TO BE FILLED OUT AT FUTURE VISITS) ***
PLEASE NOTE ANY CHANGES IN MEDICATIONS OR ALLERGIC REACTIONS AND WRITE THEM BELOW.
PLEASE SIGN AND DATE EVEN IF THERE ARE NO CHANGES AT FUTURE VISIT.***

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PATIENT SIGNATURE/GUARDIAN DATE D.D.S. INITIALS