NAME | DATE | DENTIST WHO REFERRED YOU

ADDRESS | CITY | ZIP | TELEPHONE (Home)

TELEPHONE (Work or Parent's Work) | TELEPHONE (Cell) | EMAIL ADDRESS

DATE OF BIRTH | SS# | MARITAL STATUS | EMPLOYER OR PARENT'S EMPLOYER

SPOUSE'S OR PARENT'S NAME (Circle One) | SPOUSE'S OR PARENT'S EMPLOYER (Circle One)

LAST PHYSICAL EXAMINATION | PHYSICIAN | EMERGENCY CONTACT PERSON | TELEPHONE

DENTAL INSURANCE | NAME OF INSURED | SS# OF INSURED | DOB OF INSURED

PRESENT DENTAL COMPLAINTS

HEALTH QUESTIONNAIRE (Circle "Yes" or "No")

1. Other than checkups, have you ever been under the care of a physician in the last two years? ________ Yes No
2. Are you taking any blood thinning medications, such as **ASPIRIN**? Please list ________ Yes No
3. Are you currently taking any medications, vitamins, or herbal remedies? Please list ________ Yes No
4. Are you allergic or sensitive to any substance (pollen, soaps, food, latex, etc.) ________ Yes No
5. Are you allergic to any drug or medicine (penicillin, sulfa, codeine, local anesthetic, etc.)? ________ Yes No
6. Have you ever experienced excessive bleeding from a cut or injury, surgery, or tooth extraction? ________ Yes No
7. Have you ever had radiation or chemo treatments of the head, neck, face or other areas of the body? ________ Yes No
8. Do you have a surgical implant such as a **PROSTHETIC HEART VALVE, PACEMAKER, OR ARTIFICIAL JOINT?** ________ Yes No
9. Do you take prophylactic antibiotics (SBE) prior to dental appointment? If so, what? ________ Yes No
10. Are you pregnant? ________ Ever had Cancer? ________ What kind? ________ Yes No
11. Have you ever taken medication for **BONE DENSITY?** If so, what? ________ How Long? ________ Yes No
12. Do you smoke? ________ How Long? ________ Yes No
13. Please circle the following conditions that you have experienced or been treated for:

Anemia
Arthritis
Asthma
Autoimmune Disease
Congenital Heart Defects
Congestive Heart Failure (Weakened Heart)
Diabetes (Type I or II)
Emphysema
Epilepsy or Seizures
Fainting
Heart Attack (Coronary)
Heart Murmer
High Blood Pressure
HIV
Irregular Heartbeat or Pulse
Kidney or Bladder Infection
Liver Disease (Hepatitis - A,B or C))
Pneumonia
Psychiatric Counseling or Treatment
Rheumatic Fever
Shortness of Breath
Stroke or Paralysis
Thyroid Condition (High or Low)
Tuberculosis
Ulcers
Other ________

14. Have you had previous periodontic treatment? ☐ Yes ☐ No If yes, with whom? ________

May we have your permission to request additional medical information? Please sign________

Please see back copy for your signature concerning our Privacy Practices.