DATE _____ EMAIL _____

CELL # _____ HOME # _____ WORK # _____

NAME _____

Residence _____

_____ Zip _____

Date of Birth ___/___/___ Soc. Sec. # _____

Occupation _____

Physician's Name _____ Tel. # _____

When did you last see a dentist? _____

How did you find out about us? _____

Dental insurance? What plan? _____

I certify that I have read and understand ALL the questions. I acknowledge that these questions have been answered correctly. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. ALSO, I UNDERSTAND THAT IF MY MEDICAL CONDITION CHANGES CONCERNING ANY ANSWERS ON THIS FORM SUCH AS ALLERGIES, MEDICATIONS, DISEASES ETC. I WILL INFORM THE DOCTOR IMMEDIATELY.

_____

Signature of Patient

Do you have or did you ever have *(please check)*	**YES**	**NO**
Diabetes	( )	( )
High Blood Pressure	( )	( )
Artificial Heart valves	( )	( )
Joint Replacement	( )	( )
Prosthetic, or artificial device	( )	( )
Tuberculosis	( )	( )
Emphysema	( )	( )
Hepatitis	( )	( )
Liver Disease	( )	( )
Kidney Disease	( )	( )
Asthma	( )	( )
Bleeding Problems	( )	( )
Thyroid Problems	( )	( )
Epilepsy	( )	( )
Heart or By-pass Surgery	( )	( )
Are you taking any medication (incl.Asprin)?	( )	( )
Please List_____		
_____		
_____		
Are you allergic to any medications?	( )	( )
Please List_____		
_____		
Are you pregnant?	( )	( )
Have you been diagnosed as having HIV or AIDS?	( )	( )
Is there any other Medical information that you feel we should know about?	( )	( )
Please List_____		
_____		