Name ______________________ Employer ______________________
Address ______________________ Address ______________________
City & Zip ______________________ City & Zip ______________________
Phone # __________ Cell __________ Phone # ______________________
Age ______ Birthdate ______________________ Insurance Co. ______________________
Sex ______ Marital Status ______________________ Soc. Sec. # ______________________
Spouse/Parent ______________________
Physician ______________________ Phone # ______________________
In Case of Emergency: (Closest Relative or Friend) ______________________
______________________ Address ______________________
Phone # ______________________ City & Zip ______________________

HEALTH HISTORY

Has there been any problem in your general health within the past 5 years?
(Serious illness, hospitalization, surgery) ______________________
If so, what was the problem? ______________________
The date of your last medical check-up: ______________________
Are you under a physician's care now? ______________________
If so, for what? ______________________
What tablets, pills or liquids do you take? (that includes aspirin, vitamins, tonics, etc.)
____
____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	Yes	No
Rheumatic fever, rheumatic heart disease	____	____
Heart trouble, heart attack, high blood pressure, stroke	____	____
Pain in chest, shortness of breath, swollen ankles	____	____
Blood disorders, anemia	____	____
Blood test with unusual result	____	____
Abnormal bleeding, prolonged healing, bruises easily	____	____
Asthma, hay fever	____	____
Low blood pressure	____	____
Fainting spells, seizures	____	____
Hepatitis, juandice, liver disease	____	____
Arthritis	____	____
Kidney troubles	____	____
Tuberculosis, other lung ailments	____	____
Persistent cough, cough up blood	____	____
V.D., Gonorrhea, Syphilis	____	____
Diabetes	____	____
Radiation treatment for a tumor or other growth	____	____
Sores that did not heal within one week	____	____
Women: Are you pregnant?	____	____
Sensitive or allergic to penicillin	____	____

Codeine ______ Novocaine ______ Aspirin ______
Anesthetics: ______________
Other Drugs: ______________

Have you tested positive to the HIV Virus?	____	____
Do you have any disease, condition or problem not listed above that you think the doctor should know about?	____	____
1. Are you satisfied with your previous dental care?	____	____
2. Have you ever had a bad dental experience?	____	____
3. Has the fear of discomfort kept you from having dental care?	____	____
4. Have you ever been given instructions on how to brush and floss your teeth?	____	____

5. What problems are you having with your mouth? ______________________
____

Date ______________________ Signature ______________________

Referred By: