PERSONAL INFORMATION

Date ______________________

Name to be called ______________________

Last Name ______________________ First ______________________ Middle ______________________

Address ______________________ City/State ______________________ Zip ____________

Home Phone # ______________ Business Phone # ______________ Mobile Phone # ______________

Birth Date ______________________ Sex: M or F (Circle One)

Referred By ______________________ Employer ______________________

Do you have dental insurance? __________ Insurance Company ______________________

Your Social Security # ______________________ Spouse's Social Security # ______________________

Nearest friend or relative ______________________ Phone # ______________________

HEALTH HISTORY

(Circle One)

1. Are you now under the care of a physician? If so, what is the condition being treated? ______________________ YES NO

2. Have you been hospitalized or had a serious illness within the past five years? If so, what was the problem? ______________________ YES NO

3. Have you had a blood transfusion in the past three years? YES NO

4. Circle any of the following conditions or diseases you have or have had.

mitral valve prolapse	aids	diabetes
joint replacement (hip, knee, shoulder)	rheumatism	venereal disease
rheumatic fever	hepatitis	allergies ______________
rheumatic heart disease	jaundice	asthma
heart trouble	liver disease	seizures
heart attack	tuberculosis (TB)	psychiatric treatment
high blood pressure	arthritis	other ______________
stroke	sinus trouble	

5. Have you had abnormal bleeding associated with previous extractions, trauma, or surgery? If so, what was the problem? ______________________ YES NO

6. Are you pregnant? If so, when is your baby due? ______________________ YES NO

7. Are you taking any drug, medicine or pills? If so, what? ______________________ YES NO

8. Are you allergic or have you reacted adversely to any medicine? If so, what? YES NO ______________________

9. Have you ever had a blood test for hepatitis or aids? What were the results? YES NO ______________________

10. Has your medical doctor ever informed you that you need antibiotic pre-medication prior to dental treatment? If so, what? YES NO ______________________

11. Do you have any disease, condition or problem not listed above that you think the dentist should know about? If so, what? ______________________ YES NO

12. Have you had any unusual or serious difficulties associated with previous dental treatment? If so, explain. ______________________ YES NO ______________________

Signature of patient or parent ______________________