DATE _____

PATIENT INFORMATION

PLEASE PRINT

PATIENT'S NAME ❒ Mr. ❒ Mrs. ❒ Miss. ❒ Ms.	DATE OF BIRTH	AGE	SOCIAL SECURITY #
ADDRESS ❒ PERMANENT ❒ TEMPORARY	CITY and STATE	ZIP CODE	HOME PHONE #
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF A STUDENT)	HOW LONG EMPLOYED	BUS. PHONE #
EMPLOYERS STREET ADRESS	CITY and STATE		ZIP CODE
SPOUSE or PARENT'S NAME	# OF CHILDREN and AGES		PHONE #
ADDRESS	CITY and STATE		ZIP CODE

Who referred you to us? _____

In the following questions, check no or yes, whichever applies. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past year? ❒ No ❒ Yes
2. When was your last physical examination? _____
3. Are you now under the care of a physician? ❒ No ❒ Yes
   If so, what is the condition being treated? _____
4. The name of my physician is _____
   Address _____
   Phone # _____
5. Have you had any serious illness or operation? ❒ No ❒ Yes
   If so, what was the illness or operation? _____
6. Have you been hospitalized or had a serious illness within the past five (5) years? ❒ No ❒ Yes
   If so, what was the problem? _____
7. Are you taking any drug or medicine? ❒ No ❒ Yes
   If so, what ? _____
8. Do you or have you smoked or used tobacco products? ❒ No ❒ Yes
   If so, what and how often? _____
9. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease ❒ No ❒ Yes
   b. Congenital heart lesions, heart murmur ❒ No ❒ Yes
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ❒ No ❒ Yes
      1) Do you have pain in chest upon exertion? ❒ No ❒ Yes
      2) Are you ever short of breath after mild exercise? ❒ No ❒ Yes
      3) Do your ankles swell? ❒ No ❒ Yes

Continued on next page

4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ❒ No ❒ Yes

d. Allergies ❒ No ❒ Yes

If so, specify _____

e. Sinus trouble ❒ No ❒ Yes

f. Asthma or hay fever ❒ No ❒ Yes

g. Hives or a skin rash ❒ No ❒ Yes

h. Fainting spells or seizures ❒ No ❒ Yes

i. Diabetes ❒ No ❒ Yes

If yes, do you take insulin? ❒ No ❒ Yes

j. Hepatitis, jaundice or liver disease ❒ No ❒ Yes

k. Arthritis ❒ No ❒ Yes

l. Inflammatory rheumatism (painful swollenjoints) ❒ No ❒ Yes

m.Stomach ulcers ❒ No ❒ Yes

n. Kidney trouble ❒ No ❒ Yes

o. Tuberculosis ❒ No ❒ Yes

p. Do you have a persistent cough or cough up blood? ❒ No ❒ Yes

q. Low blood pressure ❒ No ❒ Yes

r. Venereal disease (Herpes, Syphilis, Gonorrhea) ❒ No ❒ Yes

s. AIDS, ARC, HTL Virus ❒ No ❒ Yes

t. Prosthetic replacements (Hip, Knee, Valve, etc.) ❒ No ❒ Yes

u. Alcoholism or substance abuse ❒ No ❒ Yes

10. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ❒ No ❒ Yes

a. Do you bruise easily? ❒ No ❒ Yes

b. Do wounds tend to heal slowly? ❒ No ❒ Yes

c. Have you ever required a blood transfusion? ❒ No ❒ Yes

If so, explain the circumstances _____

_____

11. Do you have any blood disorder such as anemia? ❒ No ❒ Yes

12. Are you presently dieting? ❒ No ❒ Yes

If for medical reasons, please specify _____

13. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips? ❒ No ❒ Yes

14. Are you taking any of the following:

Check applicable box

❒ Antibiotics or sulfa drugs
❒ Aspirin
❒ Anticoagulants (blood thinners)
❒ Insulin, tolbutamide (Orinase) or similar drug
❒ Medicine for high blood pressure
❒ Digitalis or drugs for heart trouble
❒ Cortisone (steriods)
❒ Nitroglycerin
❒ Tranquilizers
❒ Anti depressants, MAO inhibitors
❒ Antihistamines
❒ Other

15. Are you allergic or have you reacted adversely to:

- ❒ Local anesthetics
- ❒ Penicillin or other antibiotics
- ❒ Sulfadrugs
- ❒ Barbiturates, sedatives, or sleeping pills
- ❒ Aspirin
- ❒ Iodine
- ❒ Other_____

16. Have you had any serious trouble associated with any previous dental treatment? ❒ No ❒ Yes

If so, explain _____

17. Do you have any disease, condition, or problem not listed above that you think I should know about? ❒ No ❒ Yes

If so, please explain _____

18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ❒ No ❒ Yes

19. Are you wearing contact lenses? ❒ No ❒ Yes

WOMEN

20. Are you pregnant? ❒ No ❒ Yes

21. Do you have any problems associated with your menstrual period? ❒ No ❒ Yes

22. **DENTAL HISTORY**

a. When was your last Dental visit _____

b. Do you have pain in or near your ears? ❒ No ❒ Yes

c. Do you have unhealed injuries or inflammed areas in or near mouth? ❒ No ❒ Yes

d. Have you ever had growths or long-term sores in your mouth? ❒ No ❒ Yes

e. Does your mouth or teeth hurt when you clench your teeth? ❒ No ❒ Yes

f. Do you have a habit of grinding or clenching your teeth? ❒ No ❒ Yes

g. Have you had local anesthetics before? ❒ No ❒ Yes

(explain any problems)_____

h. Do you have special problems or concerns about your teeth? ❒ No ❒ Yes

Comment: _____

i. Are your teeth sensitive to heat, cold, sweets? ❒ No ❒ Yes

j. Are you nervous about having dental treatment? ❒ No ❒ Yes

Comment:_____

k. When were your last dental X-Rays (explain)_____

l. Who was your previous Dentist _____ Phone #_____

Your signature below means you understand all of the above questions and have answered them to the best of your ability.

Signature (parent or guardian, if patient is under 18) _____ Date _____

INSURANCE INFORMATION

NAME OF EMPLOYER	I.D./SOC. SEC. #	GROUP/POLICY #
NAME OF INSURANCE CO.	INSURANCE PHONE #	EFFECTIVE DATE
NAME OF INSURED		D.O.B. OF INSURED
SECONDARY INSURANCE CO.		I.D./SOC. SEC. #
NAME OF EMPLOYER	EFFECTIVE DATE	GROUP/POLICY #
NAME OF INSURED		D.O.B. ON INSURED

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____

SIGNED (INSURED PERSON)

Doctor's Remarks