Health History

Mr. Mrs. Miss Ms. ______________ Birthdate ________ Age ______ Soc. Sec. No. ________

Home address ______________ City ________ State ______ Zip ______ Phone ________

Dental Insurance ______________ Group or Plan No. ________ Referred By ________

Person financially responsible ______________ Relationship to you ________ Soc. Sec. No. ________

Spouse/Partner name ______________ Birthdate ________ Employer ________ Soc. Sec. No. ________

Occupation ______________ Employer ______________ Phone ________

Person to contact in case of emergency ______________ Phone ________

Medical History

Physician ______________ Address ______________ Phone ________

Are you in good health? ______ If no, explain ______________

Do you have an existing illness? ______ If yes, explain ______________

Have you been hospitalized in the past two years? ______ If yes, explain ______________

Do you bleed excessively when cut? ______ Do you smoke? ______ If yes, how much? ______

Are you taking any medication, pills or drugs? ______ If yes, please list: ______________

Do you now have, or have you had any of the following? (If yes, describe under remarks.)

		YES	NO			YES	NO
1.	Heart Disease	❑	❑	14.	Liver Disease	❑	❑
2.	High Blood Pressure	❑	❑	15.	Kidney Disease	❑	❑
3.	Blood Disease	❑	❑	16.	Hepatitis	❑	❑
4.	Rheumatic Fever	❑	❑	17.	Asthma	❑	❑
5.	Heart Murmur	❑	❑	18.	Tuberculosis	❑	❑
6.	Diabetes	❑	❑	19.	AIDS or HIV positive	❑	❑
7.	Stroke	❑	❑	20.	Allergy to: (a) Penicillin	❑	❑
8.	Epilepsy	❑	❑		(b) Other Antibiotics	❑	❑
9.	Arthritis	❑	❑		(c) Local Anesthetics	❑	❑
10.	Tumor History	❑	❑		(d) Other	❑	❑
11.	VD	❑	❑	21.	Are you pregnant?	❑	❑
12.	Nervous Disorders	❑	❑	22.	Have you ever used Fen-Phen?	❑	❑
13.	Radiation Treatment	❑	❑				

Dental History

Do you have any present dental complaints? ❑ Yes ❑ No What? ______________

When was your last full-mouth X-ray taken? ______________ Where? ______________

When was your last cleaning? ______________ Where? ______________

Have you ever been instructed in the prevention of decay? ______________

Have you ever been instructed in caring for your gums? ______________

Remarks

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____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient.

I also agree to assume full financial responsibility for all treatment rendered.

Signature ______________ Date ______________