PLEASE PRINT AND FILL OUT COMPLETELY

PATIENT'S NAME_____ADDRESS_____APT #_____

CITY_____STATE_____ZIP_____HM #_____WK#_____DOB_____

PATIENT'S SS # _____ SEX _____ MARITAL STATUS _____ EMPLOYER _____

Cell#_____EMAIL_____**REFERRED BY**_____

Best form of contact: Calls Text Email

GUARDIAN(under 18)_____ADDRESS_____APT #_____

CITY_____STATE_____ZIP_____HM #_____WK #_____DOB_____ CELL

GUARDIAN'S SS #_____SEX_____MARITAL STATUS_____EMPLOYER_____

SUBSCRIBER'S NAME_____ADDRESS_____APT #_____

CITY_____STATE_____ZIP_____HM #_____WK #_____DOB_____

SUBSCRIBER SS #_____SEX_____MARITAL STATUS_____EMPLOYER_____

INS. CO_____PLAN NAME_____INS. PH.#_____RELATION TO PATIENT_____

MEDICAL HISTORY-Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE

		YES	NO
1.	Asthma, hay fever, sinusitis, or other allergies (**PLEASE CIRCLE WHICH ONE)**	____	_____
2.	Allergy to Penicillin, aspirin, local or general anesthetic , or other drugs:(**PLEASE CIRCLE WHICH ONE)**	____	_____
3.	Blood pressure or heart problems/ joint replacements (**PLEASE CIRCLE WHICH ONE)**	____	_____
4.	Rheumatic fever or heart murmur (**PLEASE CIRCLE WHICH ONE)**	____	_____
5.	A pacemaker or open heart surgery (**PLEASE CIRCLE WHICH ONE)**	____	_____
6.	Diabetes, liver, kidney, thyroid, or lung problems (**PLEASE CIRCLE WHICH ONE)**	____	_____
7.	Ulcers or stomach problems (**PLEASE CIRCLE WHICH ONE)**	____	_____
8.	Hepatitis or jaundice (**PLEASE CIRCLE WHICH ONE)**	____	_____
9.	Epilepsy or nervous disorders (**PLEASE CIRCLE WHICH ONE)**	____	_____
10.	Bleeding or clotting disorders(**PLEASE CIRCLE WHICH ONE**)	____	_____
11.	Arthritis	____	_____
12.	Herpes or canker sores(**PLEASE CIRCLE WHICH ONE**)	____	_____
13.	Acquired immune deficiency syndrome (HIV or AIDS)	____	_____
14.	Any other illness**(PLEASE SPECIFY, IF YES)**	_____	_____
15.	Do you smoke or use tobacco products?	_____	_____
16.	Are you presently taking any medicine?_____ **SPECIFY:**_____		_____
17.	Are you presently under the care of a physician?_____		_____
18.	When was your last physical exam?_____		
19.	Have you ever been hospitalized?_____ Date:_____ Reason:_____		
20.	Have you had X-ray treatment or chemotherapy?	_____	_____
21.	Are you presently on a diet?	_____	_____
22.	Women: Are you taking birth control pills?: (Yes / No) Are you pregnant?: (Yes / No)		

Doctor Signature: Date:

Patient/Guardian Signature X: Date: