Name: _____ Sex: M / F Date of Birth: _____

If minor, Parent(s)/Guardian(s) Name(s): _____ Marital Status: _____

Driver's License #: _____ Social Security Number: _____

Email:_____ Preferred Pharmacy:_____

Cell: _____ May we leave a message: Yes / No

Home Phone: _____ May we leave a message: Yes / No

Address: _____

City, State, Zip: _____

Dental Insurance Company: _____ Employer: _____ Group Number: _____

Phone Number: _____ Subscriber's Name: _____

Subscriber ID Number/Social Security Number: _____

Secondary Dental Insurance Company: _____ Employer: _____ Group Number: _____

Phone Number: _____ Subscriber's Name: _____

Subscriber ID/Social Security Number: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number:_____

Whom may we thank for referring you to our office: _____

Do you currently/have you ever had any of the following: Active Tuberculosis / Persistent cough greater than 3 weeks / Cough that produces blood / been exposed to anyone with Tuberculosis?

IF YOU RESPONDED YES TO ANY OF THE 4 ITEMS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST

Physician Name / Phone Number / City, State: _____

Have you been hospitalized in the past 5 years? If yes, why? _____

Please list **ALL** medications (prescribed and over the counter): _____

Date of last physical exam: _____ Height:_____ Weight: _____

Are you in overall good health? If no, please explain what is being treated:_____

Do you have any history of the following?

○ Bladder Issues	○ Bone/Joint Disorders	○ Artificial Joints/Heart Valves
○ Contact Lenses	○ Eating Disorder	○ Congestive Heart Failure
○ Premedication for Dental Treatment	○ High/Low Blood Pressure	○ Anemia
○ Arthritis	○ Asthma	○ Cerebral Palsy
○ Chicken Pox	○ Chronic Sinusitis	○ Bleeding Disorders
○ Cancer	○ Sleep Disorder	○ Snoring
○ Sleep Apnea	○ Osteoporosis	○ Diabetes
○ Ear Aches	○ Epilepsy	○ Fainting
○ Growth Problems	○ Hearing Loss	○ Heart Conditions
○ Hepatitis	○ HIV +/AIDS	○ Kidney Disorders
○ Liver Disease	○ Measles/Mumps	○ Pregnancy/Nursing
○ Rheumatic Fever	○ Seizures	○ Sickle Cell
○ Thyroid Problems	○ Tobacco/Drug Use	○ STD/Venereal Disease

Are you allergic to or have you ever had a reaction to: If yes, please describe reaction.

o Local Anesthetics _____

o Penicillin or other antibiotics _____

o Aspirin _____

o Sulfa Drugs_____

o Codeine or other narcotics_____

o Iodine_____

o Latex_____

o Metals_____

o Hay Fever/Seasonal_____

o Animals_____

o Food_____

o Any other alleriges_____

Dental Information/History:

○ Bleeding Gums
○ Tooth Sensitivity
○ Dry Mouth
○ Periodontal Gum Treatments/Surgery
○ Orthodontic Treatment
○ Problems with past dental treatment
○ Drink Fluoridated Water
○ Drink Bottled/Filtered Water
○ Dental Pain/Discomfort
○ Earaches/Neck Pains
○ Clicking/Popping/Discomfort in the Jaw Joint
○ Grind your teeth
○ Sores/Ulcers in your mouth
○ Wear Dentures/Partials
○ Serious Injury to head/neck/mouth

Reason for today's visit:_____ Date of last dental exam:_____ Date of last dental x-rays:_____

Is there anything else the Doctor should know about your health? IF yes, please explain in detail: _____

_____

I will discuss any and all relevant patient health issues with the provider prior to any dental treatment. Initial _____

I certify that I have read and understand the above and that the information given on this form is true and accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Printed Name: _____ Signature of Patient/Legal Guardian: _____

Relationship to Patient: _____ Date: _____

Signature of Dentist: _____ Date: _____