

WELCOME

Name _____ Male _____ Female _____ Birth date _____
Mo. Day Year

Address _____ City _____ Zip _____ Home Phone _____

Single _____ Married _____ Widowed _____ Divorced _____ Cell Phone _____

Children's Names _____ E-mail _____

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Dental Insurance Co. _____ Social Security Number _____

Whom May We Thank For Referring You? _____

SPOUSE INFORMATION Birth date _____

Spouse Name _____ Home Phone _____

Address _____ City _____ Zip _____ Cell Phone _____

Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Dental Insurance Co. _____ Social Security Number _____

Last Dental Visit _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING

	No	Yes		No	Yes		No	Yes
Poor Health	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures/Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia/Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemo/Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGY TO:		
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Novocaine	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Codeine/Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A/B	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Bulimia/Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Other Drugs	<input type="checkbox"/>	<input type="checkbox"/>
H.I.V./A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>						

Date Of Last Medical Exam / Reason _____ Medical Dr. Name _____

	No	Yes	If yes, please list
Have you ever been put to sleep for an operation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever responded unfavorably to medical or dental care? ..	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been hospitalized within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other health condition we should know about?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you now taking medicine of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If so, please list _____			_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____