

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Social Security # _____ Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Single: _____ Married: _____ Employer: _____ Name of Spouse: _____

Name of Dental Ins. Company: _____ Group#: _____

Dental Ins. Subscriber: _____ Ins.Subscriber's ID#: _____

Dental Ins. Subscriber's Date of Birth: _____ Dental Ins. Subscriber's Employer: _____

Closest Relative: _____ Phone: _____ Referred By: _____

If you are completing this form for another person, what is your relationship to that person? _____

1. Are you presently taking any medications? YES NO

If so, what? _____

2. Are you allergic to or have you had a reaction to any medication or drug? YES NO

If so what? _____

3. Have you been under the care of a physician during the past 2 years? YES NO

If so why? _____

4. Have you been hospitalized in the past 2 years? YES NO

If so why? _____

5. When you walk upstairs do you have chest pain, shortness of breath or feel tired? YES NO

6. Have you ever been treated for a tumor or growth? YES NO

7. Have you ever had any serious difficulty with previous dental treatment? YES NO

8. When was your last visit to the dentist? _____

9. Do you have any recent dental x-rays (within the last 2 years) from another dentist? If so, who YES NO

was your previous dentist? _____

10. Do you have any specific dental complaints? If so, what are they? YES NO

11. Who is your physician? _____

Circle any of the following that you have or have had:

Congenital heart defects	Anemia (Blood Problems)	Hemophilia	Heart attack or Heart trouble
Arthritis	Hepatitis	Rheumatic Fever	Artificial Joints
Stroke	Heart Murmur	Asthma	Thyroid Problems
Angina	Chronic Bronchitis	Tuberculosis (TB)	High Blood Pressure
Diabetes	Psychiatric Treatment	Heart Pacemaker	Emphysema
AIDS or HIV infection	Artificial Heart Valve	Epilepsy or Seizures	Venereal Disease

Do you have any disease, condition, or problem not listed? YES NO

If so, what? _____

Signature: _____

E-Mail Address: _____