**PATIENT NAME: SEX: DATE OF BIRTH: S.S.# INSURANCE ID#**

**PREFFERED NAME: PHONE NOS: (HOME): (CELL): (WORK):**

**ADDRESS: APT/UNIT NO: CITY: STATE: ZIPCODE: \_\_\_\_\_\_\_\_\_**

**PARENT/SPOUSE’S NAME: DOB: E-MAIL ADDRESS:**

**IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED, BESIDES PERSON LISTED ABOVE? PHONE NUMBER:**

**WHOM MAY WE THANK FOR REFERRING YOU?**

**FEMALES: ARE YOU PREGNANT OR TRYING TO GET PREGNANT? IF SO, DUE DATE: ARE YOU NURSING?**

**NAME OF OB/GYN DR: PHONE NO: ARE YOU TAKING ORAL CONTRACEPTIVES?**

**LIST ANY MEDICATIONS, NOTING REASON, DOSEAGE& FREQUENCY (USE SEPARATE PAGE IF TOO MANY TO LIST);**

**HAVE YOU HAD MAJOR SURGERY OR BEEN HOSPITALIZED IN PAST FIVE YEARS? Reason/ Date:**

**HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY?**

**ARE YOU UNDER A PHYSICIAN’S CARE NOW: IF SO, PLEASE EXPLAIN:**

**PHYSICIAN’S NAME/PHONE NUMBER: DATE OF LAST PHYSICAL EXAM:**

**Are you allergic to any of the following? ASPIRIN: PENICILLIN: CODEINE: LATEX:**

**SULFA DRUGS: LOCAL ANESTHESIA: ACRYLIC: FOOD/OTHER ALLERGY: <explain>**

**Does patient have, or has ever had, any of the following? Does patient use tobacco products? □Yes □No**

 **YES NO YES NO YES NO YES NO**

**AIDS/HIV POSITIVE □ □ CORISONE MEDICINE □ □ HEMOPHELIA □ □ RADIATION TREATMENTS □ □**

**ALZHEIMER’S □ □ DIABETES □ □ HEPATITIS A □ □ RECENT WEIGHT LOSS □ □**

**ANAPHYLAX □ □ DRUG ADDICTION □ □ HEPATITIS B or C □ □ RENAL DIALYSIS □ □**

**ANEMIA □ □ EASILY WINDED □ □ HERPES □ □ RHEUMATIC FEVER □ □**

**ANGINA □ □ EMPHYSEMA □ □ HIGH BLOOD PRESSURE □ □ RHEUMATISM □ □**

**ARTHRITIS/GOUT □ □ EPILEPSY OR SEIZURES □ □ HIGH CHOLESTEROL □ □ SCARLET FEVER □ □**

**ART.HEART VALVE □ □ EXCESSIVE BLEEDING □ □ HIVES OR RASH □ □ SHINGLES □ □**

**ARTIFICIAL JOINT □ □ EXCESSIVE THIRST □ □ HYPOGLYCEMIA □ □ SICKLE CELL DISEASE □ □**

**ASTHMA □ □ FAINTING /DIZZINESS □ □ IRREGULAR HEARTBEAT □ □ SINUS TROUBLE □ □**

**BLOOD DISEASE □ □ FREQUENT COUGH □ □ KIDNEY PROBLEMS □ □ SPINA BIFADA □ □**

**BLOOD TRANS □ □ FREQUENT DIARRHEA □ □ LEUKEMIA □ □ STOMACH/INTEST DISEASE □ □**

**BREATHING PROBLEMS □ □ FREQUENT HEADACHE □ □ LIVER DISEASE □ □ STROKE □ □**

**BRUISE EASILY □ □ GENITAL HERPES □ □ LOW BLOOD PRESSURE □ □ SWELLING OF LIMBS □ □**

**CANCER □ □ GLAUCOMA □ □ LUNG DISEASE □ □ THYROID DISEASE □ □**

**CHEMOTHERAPY □ □ HAY FEVER □ □ MITRAL VALVE PROL □ □ TONSILLITIS □ □**

**CHEST PAINS □ □ HEART ATTACK/FAILURE □ □ OSTEOPOROSIS □ □ TUBERCULOSIS □ □**

**Cold Sore/Fever Blisters □ □ HEART MURMUR □ □ PAIN IN JAW JOINTS □ □ TUMORS OR GROWTHS □ □ CONG.HEART DISORDER □ □ HEART PACEMAKER □ □ PARATHYROID DISEASE □ □ ULCERS □ □**

**CONVULSIONS □ □ HEART TROUBLE/DISEASE □ □ PSYCHIATRIC CARE □ □ VENEREAL DISEASE □ □**

 **YELLOW JAUNDICE □ □**

**Has patient ever had or has any serious illness or conditions not listed above? □Yes □No If “yes”, please list:**

**ADDITIONAL INFORMATION/COMMENTS:**

***TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT’S) HEALTH: IT IS MY RESPONSIBLITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.***

**SIGNATURE OF PATIENT,PARENT OR GUARDIAN: DATE:**