NAME/MS.
MISS/MR.
MRS./DR.__ DATE _____/_____/_____

LAST MI FIRST SS# _____--____--_____

ADDRESS_____ DATE OF BIRTH ___/___/_____
STREET CITY/TOWN ZIP

HOME PHONE ( )_____CELL ( )_____ E-MAIL_____

OCCUPATION_____PLACE OF WORK_____ WORK PHONE ( )_____

REFERRING DENTIST_____
NAME CITY/TOWN

CONTACT IN CASE OF EMERGENCY_____RELATIONSHIP_____ PHONE( )_____

REASON FOR THIS VISIT _____

CHECK IF YOU HAD BEEN CARED FOR BY ANY OF THE FOLLOWING:
□ ORTHODONTIST □ PERIODONTIST □ ORAL SURGEON □ OTHER NAME _____

PHYSICIAN'S NAME_____ PHONE ( )_____

ARE YOU NOW OR HAVE YOU RECENTLY BEEN UNDER A PHYICIAN'S CARE? Y / N

IF YES, FOR WHAT REASON _____

CHECK IF YOU ARE ON ANY OF THE FOLLOWING MEDICATION:
□ STEROID □ SYNTHROID □ COUMADIN □ PLAVIX □ ASPIRIN

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, IF ANY _____

_____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

□ DIABETES	□ CONGENITAL HEART DEFECT	□ HERPES
□ ALLERGIES	□ RHEUMATIC FEVER	□ HIV
□ ASTHMA / HAY FEVER	□ HEART MURMUR	□ STROKE
□ SINUS PROBLEM	□ MITRAL VALVE PROLAPSE	□ DIZZY SPELLS / SEIZURES
□ EAR INFECTION	□ ARTIFICIAL VALVE	□ EPILEPSY
□ TUBERCULOSIS	□ PACE MAKER	□ NEUROLOGICAL DISORDER
□ LUNG DISEASE	□ IRREGULAR HEARTBEAT	□ GLAUCOMA
□ PNEUMONIA	□ HEART ATTACK WHEN _____	□ DRUG OR ALCOHOL ADDICTION
□ LIVER DISEASE	□ HEART SURGERY	□ PSYCHIATRIC TREATMENT
□ HEPATITIS / JAUNDICE	□ ABNORMAL BLEEDING	□ CANCER _____
□ SLOW HEALING	□ HIGH BLOOD PRESSURE	□ CHEMOTHERAPY
□ KIDNEY DISEASE	□ LOW BLOOD PRESSURE	□ RADIATION THERAPY
□ STOMACH ULCERS	□ ANEMIA	□ MAJOR OPERATION _____
□ THYROID DISEASE	□ ARTHRITIS	□ PROSTHETIC JOINTS WHEN _____

□ OTHER _____

CHECK IF YOU HAVE HAD SENSITIVITY OR ALLERGIC RESPONSE TO ANY OF THE FOLLOWING:

□ LOCAL ANESTHETICS □ EPINEPHRINE □ ASPIRIN □ CODEINE
□ LATEX □ IODINE □ ANTIBIOTICS _____
□ OTHERS _____

HAVE YOU EVER TAKEN ANTIBIOTICS BEFORE DENTAL PROCEDURES? Y / N NAME _____

DO YOU SMOKE TOBACCO? Y / N IF YES, HOW MUCH? _____

WOMEN ONLY: ARE YOU PREGNANT? Y / N HOW MANY MONTHS? _____ ARE YOU BREAST FEEDING? Y / N

PLEASE INDICATE ANY SPECIAL CONCERNS RELATED TO YOUR DENTAL TREATMENT _____

_____

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____/_____DATE ___/____/_____
SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR OR RESPONSIBLE PARTY RELATIONSHIP TO PATIENT

REV - 1/10