Please Fill Out Completely

Patient's Name_____Address_____Apt#_____

City_____State_____Zip_____Phone-C_____W_____DOB_____

Patient's SSN_____-_____-_____Sex____Marital Status____Employer_____Occupation_____

E-Mail Address _____

Guardian Name/Emergency Contact

Name_____ Phone_____

How did you hear about us? Family/Friend ____ Website____ Google____ Yelp_____ Ins co._____

Medical History- Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. **Have you ever had or have**

	YES	NO
1. Asthma, hay fever, sinusitis, or other allergies		
2. Allergy to penicillin, aspirin, local or general anesthetic, or others drugs; specify:		
3. Blood Pressure or heart problems		
4. Rheumatic fever or heart murmur		
5. A pacemaker or open heart surgery		
6. Diabetes, liver, kidney, thyroid, or lung problems		
7. Ulcers or stomach problems		
8. Hepatitis or Jaundice		
9. Epilepsy or nervous disorders		
10. Bleeding or clotting disorders		
11. Arthritis		
12. Venereal Disease, Herpes		
13. Acquired Immune Deficiency Syndrome (AIDS)		
14. Any other illnesses		
15. Do any wounds heal slowly or present complications?		
16. Are you presently taking any medicine? Specify:		
17. Are you presently under the care of a physician?		
18. When was your last physical exam?		
19. Have you ever been hospitalized? Date: Reason:		
20. Have you had X-ray treatments or chemotherapy?		
21. Are you presently on a diet?		
22. Women: Are you taking birth control pills? (Y or N) Are you pregnant? (Y or N)		

Signature_____**Date**_____**Doctor**_____**Date**_____