Health History

Mr. Mrs. Miss _____ Birthdate _____ Age _____ Soc. Sec. No. _____

Home Address _____ City _____ State _____ Zip _____ Phone _____

Dental Insurance _____ Group or Plan No. _____ Referred By _____

Person Financially Responsible _____ Relationship to you _____ Soc. Sec. No. _____

Spouse Name _____ Birthdate _____ Employer _____ Soc. Sec. No. _____

Occupation _____ Employer _____ Phone _____

Person to contact in case of emergency _____ Phone _____

Medical History

Physician _____ Address _____ Phone _____

Are you in good health? _____ If no, explain _____

Do you have an existing illness? _____ If yes, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

Are you taking any medication, pills or drugs? _____ If yes, please list: _____

Do you now have, or have you had any of the following? (If yes, describe under remarks.)

	YES	NO		YES	NO
1. Heart Disease	❑	❑	14. Liver Disease	❑	❑
2. High Blood Pressure	❑	❑	15. Kidney Disease	❑	❑
3. Blood Disease	❑	❑	16. Hepatitis	❑	❑
4. Rheumatic Fever	❑	❑	17. Asthma	❑	❑
5. Heart Murmur	❑	❑	18. Tuberculosis	❑	❑
6. Diabetes	❑	❑	19. AIDS or HIV positive	❑	❑
7. Stroke	❑	❑	20. Allergy to: (a) Penicillin	❑	❑
8. Epilepsy	❑	❑	(b) Other Antibiotics	❑	❑
9. Arthritis	❑	❑	(c) Local Anesthetics	❑	❑
10. Tumor History	❑	❑	(d) Other	❑	❑
11. VD	❑	❑	21. Are you pregnant?	❑	❑
12. Nervous Disorders	❑	❑	22. Have you ever used Fen-Phen?	❑	❑
13. Radiation Treatment	❑	❑			

Dental History

Do you have any present dental complaints? ❑ Yes ❑ No What? _____

When was your last full-mouth X-ray taken? _____ Where? _____

When was your last cleaning? _____ Where? _____

Have you ever been instructed in the prevention of decay? _____

Have you ever been instructed in caring for your gums? _____

Remarks

_____

_____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient.

I also agree to assume full financial responsibility for all treatment rendered.

Signature _____ Date _____