PATIENT INFORMATION

Name_______________ Birthdate_______________
Single Married Widowed Divorced
Address_______________
City_______________ State_______________ Zip_______________
Home Telephone_______________ Work Telephone_______________
SS#_______________ Occupation_______________
Employer_______________
Employer Address_______________

PERSON FINANCIALLY RESPONSIBLE

Name_______________ Birthdate_______________
Single Married Widowed Divorced
Address_______________
City_______________ State_______________ Zip_______________
Home Telephone_______________ Work Telephone_______________
SS#_______________ Occupation_______________
Employer_______________
Employer Address_______________

Dentist: (name)_______________ (address)_______________
Physician: (name)_______________ (address)_______________
Referred by: (name)_______________ (address)_______________
Do you have Dental Insurance? Yes No **Major Medical Insurance? Yes No**

PATIENT MEDICAL HISTORY

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health?_______________ **Yes No**

Are you now under the care of a Physician? **Yes No**
If so, what condition is being treated?_______________

Have you been hospitalized or had a serious illness within the past (5) years? **Yes No**
If so, what was the problem?_______________

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
If so, please explain _______________ **Yes No**

Are you taking any drugs or medicine? **Yes No**
If so, what?_______________

Do you smoke? **Yes No** If so, how much?_______________

Do you snore? **Yes No**

Do you have "dry mouth" at night that interferes with your sleep? YES NO

Please circle yes or no for the following:

Yes No Damaged heart valves/artificial heart valves/heart murmur _______________

Yes No Cardiovascular disease (heart attack)_______________

Yes	No	High Blood Pressure	Yes	No	Stroke
Yes	No	Asthma	Yes	No	Stomach Ulcers
Yes	No	Diabetes	Yes	No	Kidney Trouble
Yes	No	Hepatitis/Jaundice/Liver Disease	Yes	No	Tuberculosis
Yes	No	Anemia	Yes	No	Low Blood Pressure
Yes	No	Venereal Disease	Yes	No	Epilepsy
Yes	No	AIDS or other immunosuppressive disorder	Yes	No	Cancer

Are you allergic or have you acted adversely to:

			Yes	No	Penicillin _______________
Yes	No	Local Anesthetics	Yes	No	Other antibiotic_______________
Yes	No	Sulfa Drugs	Yes	No	Aspirin _______________
Yes	No	Barbiturates, sedatives, sleeping pills	Yes	No	Codeine or other narcotic_______________
Yes	No	Iodine	Yes	No	Other_______________

Do you have any disease, condition, or problem not listed above that you think I should know about? _______________

WOMEN Are you pregnant? **Yes No** Are you nursing? **Yes No**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.

____
Signature of Patient Date

____
Signature of Parent (if patient is a minor) Date