Name _____ Address_____

City _____ State _____ Zip_____

Phone#. Home_____ Cell_____ work _____

SS# _____ Birthdate _____ Marital status _____

Name of responsible party_____ Ins. coverage (Y/N)_____

Insurance Name_____

Employer Name _____

Address_____

City _____ State _____ Zip_____

Referred by _____ Medical Dr _____

Yes No **Does your medical history include any of the following?**

___ ___ 1. Are you in general good health at this time?
___ ___ 2. Are you under any medical treatment now?
___ ___ 3. Have you ever had any major operations? If so, what?
___ ___ 4. Are You Allergic To Any Medications (Penicillin, Latex)? _____
___ ___ 5. Have you ever had heart trouble?
___ ___ 6. Have you ever had high blood pressure?
___ ___ 7. Have you ever had respiratory disease?
___ ___ 8. Have you ever had diabetes?
___ ___ 9. Have you ever had tumors or growths?
___ ___ 10. Have you ever had radiation treatment?
___ ___ 11. Have you ever had blood disease?
___ ___ 12. Have you ever had liver disease?
___ ___ 13. Have you ever had kidney disease?
___ ___ 14. Have you ever had stomach or intestinal disease?
___ ___ 15. Have you ever had venereal disease?
___ ___ 16. Have you ever been tested POSITIVE for HIV (AIDS) ?
___ ___ 17. Are you PREGNANT?
___ ___ 18. Do you have a history of fainting?
___ ___ 19. Do you have pain in or near your ears?
___ ___ 20. Do you have any sensitive areas in or around your mouth?
___ ___ 21. Do you have any growths or sore spots in your mouth?
___ ___ 22. Do you have a history of clenching or grinding?
___ ___ 23. Have you ever had any difficult extractions?
___ ___ 24. Have you had reactions to dental anesthetic?
___ ___ 25. Do your gums bleed?
___ ___ 26. Do you have any dental complaints at this time?
___ ___ 27. When was your last full mouth Xrays taken? _____ Where? _____
___ ___ 28. Have you had joint replacement?
___ ___ 29. Are you now taking any medications? Please List. _____

In Case Of Emergency, Notify _____ Phone # _____

Patient or Guardian Signature _____

Date