

NAME _____ Married Single Other

Address _____ Last _____ First _____ Middle _____

Street _____ Unit # _____ City _____ State _____ Zip _____

Phone _____ Birthdate _____ Soc. Sec. # _____ Dr. Lic. # _____

EMPLOYER _____ Phone _____ Ext. _____

Address _____ City _____ Zip _____

Occupation _____ How Long Employed _____

If Married, Spouse Name _____

If Child, Parent Name _____

EMPLOYER (Spouse, Parent) _____ Phone _____ Ext. _____

Address _____ City _____ Zip _____

Occupation _____ How Long Employed _____

REFERRED BY _____

Emergency Contact Person _____ Relationship _____

Address _____ City _____ Phone _____

INSURANCE INFORMATION

Name of insurance company **PRIMARY INSURANCE**

Insured Person's Name	Birthdate	Relationship	Social Security No.
Company Name	Group No.	Plan No.	Name of Union Local

Name of insurance company **SECONDARY INSURANCE**

Insured Person's Name	Birthdate	Relationship	Social Security No.
Company Name	Group No.	Plan No.	Name of Union Local

DENTAL-MEDICAL HISTORY

Do you have a dental problem or complaint? Describe _____

Name of previous dentist _____ Why are you changing dentist? _____

When was your last dental checkup? _____

Do you brush and floss on a routine basis? _____

Do your gums bleed? Where _____

Do you want to change your smile or whiten your teeth? _____

Do you ever have clicking, popping or discomfort in the jaw joint? _____ Do you brux or grind? _____

Have you noticed any sores or growths in your mouth that don't go away? _____

Do you have a current physician? _____ Name _____

Address _____ Tel # _____

Are you under a physician's care now? _____ For What? _____

What was your last blood pressure reading _____ (Systolic) over _____ (Diastolic)

Have you ever used the drugs Fen-phen / Redux? _____

Are you taking any medications, pills or drugs? Please list and tell what each is for: _____

Are you allergic to any medications or substances? Please check box below

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

WOMEN (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____

Do you now have or have you ever had any of the following? Please check appropriate boxes. * If yes to any of the starred conditions, premedication may be required.

Yes No	Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Anemia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Fever Blisters
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Cancer	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Herpes
<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> X-Ray Treatments (Radiation)	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Hemophilia (Bleeding Problem)	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stomach/Intestinal Disease	<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Recent Blood Transfusion	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Fainting or Dizziness
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Swelling of Limbs	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Rheumatic Fever*	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Artificial Heart Valve*	<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Artificial Joint*	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Heart Pacemaker*	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Heart Surgery*	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> AIDS	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Allergies (Medicines)
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Hepatitis A (Infectious)	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Allergies (Pollen/Dust)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hives or Rash

Have you ever had any other serious illness not checked above? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____

Updates:	Doctor's	
Patient/Guardian Initials _____	Initials _____	Date _____
Patient/Guardian Initials _____	Doctor's Initials _____	Date _____
Patient/Guardian Initials _____	Doctor's Initials _____	Date _____
Patient/Guardian Initials _____	Doctor's Initials _____	Date _____