



Date _____ Marital Status: S M D W

Name _____ Date of Birth _____

Social Security # _____ Male / Female Email _____

Phone: Home _____ Work _____ Cell _____

Home Address _____

City _____ State _____ Zip _____ Emergency Contact: _____

Employer _____ Occupation _____

Dental Insurance Co. _____ Social Sec / Policy No _____

Policy in Name of _____ Date of Birth _____

Employer of Policy Holder _____ Group No _____

Referred by _____ General Dentist _____ Pharmacy & Phone _____

MEDICAL HISTORY

1. How is your general health at ths time? _____

2. Do you have or have you ever had any of the following conditions? _____

<input type="checkbox"/> Joint Replacement Date: _____	<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Stroke Date: _____	<input type="checkbox"/> Hepatitis A B C / Liver Disease
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism / Drug Addiction
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV Postiive
<input type="checkbox"/> Heart Valve Replace / Shunts	<input type="checkbox"/> Emphysema	<input type="checkbox"/> A.I.D.S.
<input type="checkbox"/> Rheumatic Fever Date: _____	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Blood Disorders
<input type="checkbox"/> Pacemaker Date: _____	<input type="checkbox"/> Arthritis / Rheumatism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Disease / Attack	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cancer / Tumors / Radiation
<input type="checkbox"/> Heart Surgery Date: _____	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Diabetes Type: _____

3. Have you ever had any serious illness or operation? ___ Yes ___ No If yes, what and when: _____

4. Do you have tendency to prolonged bleeding following injury or surgery? _____

5. Do you take any blood thinners (anti-coagulants), aspirin, Vitamin E or Fish Oil? _____

6. Have you ever taken bone density medications? Ex. Boniva, Fosamax _____

7. Are you allergic to or have you reacted adversely to any drug or medicine? _____
Please list and explain: _____

8. Please list any Prescription medications you are presently taking: _____ for _____
_____ for _____ for _____
_____ for _____ for _____
_____ for _____ for _____
_____ for _____ for _____

9. Please list any over the counter medications, herbs and / or vitamins you are presently taking: _____

10. Do you have any medical condition not mentioned above? ___ Yes ___ No If yes, please explain: _____

11. Name of your Physician _____ Approx Date of last physical _____

Women Only: Are you pregnant? ___ Yes ___ No Expected delivery date _____
Do you take birth control pills? ___ Yes ___ No Have you reached Menopause? ___ Yes ___ No