

PATIENT INFORMATION

Date _____

NAME: First, MI, Last	Patient Employer
ADDRESS	Address
City State Zip	City State Zip
Home Phone Work Phone	Occupation
Cellular E-mail	Emergency Contact
Date of Birth Age Sex <input type="checkbox"/> M <input type="checkbox"/> F Marital Status	Phone Relationship to Patient
Referring Dentist	Medical Physician
Referring Orthodontist	Phone #
Wife/Mother Name:	Husband/Father Name:
Address	Address
City State Zip	City State Zip
Home Phone Work Phone	Home Phone Work Phone
Cellular Date of Birth	Cellular Date of Birth
Employer	Employer

What are we seeing you for today? _____

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| <ol style="list-style-type: none"> 1. Are you in good health? YES NO 2. Has there been any change in your general health in the last year? YES NO 3. Are you now under a physicians care for a particular problem? YES NO 4. Have you had any serious illnesses, operations or hospitalizations? YES NO
If so, describe _____ 5. Have you ever had excessive bleeding requiring special treatment? YES NO 6. Are you subject to fainting, dizziness, convulsions, seizures or epilepsy? YES NO 7. Have you ever had Asthma, Emphysema, Tuberculosis, Pneumonia or difficulty breathing? YES NO 8. Have you ever had any of the following: <ul style="list-style-type: none"> a) Heart Problem YES NO b) Stroke YES NO c) Rheumatic Fever or Heart Murmur YES NO d) Liver Disease, Hepatitis, Jaundice YES NO e) Kidney Disease YES NO f) High or Low Blood Pressure YES NO g) Diabetes YES NO h) Anemia YES NO i) Stomach Ulcers YES NO j) Thyroid Disease (goiter) YES NO k) Glaucoma YES NO l) Implants placed anywhere in your body (heart valve, hip, knee) YES NO m) Any disease, drugs or transplant operation that has depressed your immune system YES NO n) AIDS / ARC / HIV YES NO 9. Are you wearing contact lenses? YES NO | <ol style="list-style-type: none"> 10. Are you using or taking any of the following: <ul style="list-style-type: none"> a) Antibiotics YES NO b) Anticoagulants (Plavix, Coumadin) YES NO c) High Blood Pressure medication YES NO d) Steroids (Cortisone) YES NO e) Tranquilizers (Valium) YES NO f) Insulin or oral Diabetes medicine YES NO g) Digitalis, Inderal, Nitroglycerine or other heart medicine YES NO h) Aspirin YES NO i) Osteoporosis medications (Fosamax, Actonel, Boniva) YES NO j) WOMEN: Birth Control pills YES NO PLEASE LIST ALL CURRENT MEDICATIONS:

_____ 11. Please list all medication allergies:

_____ 12. Do you smoke or use smokeless tobacco products? YES NO 13. Have you ever sought treatment for drug abuse or alcoholism? YES NO 14. Do you have other medical conditions or concerns that the doctor should know about? YES NO

_____ 15. Have you ever been treated for or diagnosed with TMJ (JawJoint) pain, noise or limited function? YES NO 16. Do you currently have TMJ problems? YES NO 17. WOMEN: Are you pregnant or planning pregnancy? YES NO 18. Are you allergic to eggs or sulfites? YES NO |
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I understand the information I provide on this form is essential to determine my dental needs and the provision of treatment. I understand that if any change occurs in my health I will report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability, and I have had an opportunity to discuss my health history with the doctor.

Signature of persons completing health history

Doctor's Initials