Date: _____

Name _____ Date of birth _____

Home address _____ City _____ State _____ Zip _____ Phone _____

Social Security no. _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Occupation _____ Business phone _____

Employer _____ Address _____

Name of Dental Insurance Co. _____

Who may we thank for referring you to our office? _____

1. The name, address and telephone number of my physician is:

2. **Do you have or have you had any of the following?**

	Y	N
A. Rheumatic fever or rheumatic heart disease		
B. Cardiovascular disease (heart trouble)		
C. A cardiac pacemaker or artificial heart valve		
D. High blood pressure, low blood pressure		
E. Sinus trouble, asthma, hay fever		
F. Neurologic disorder, (e.g. epilepsy, seizures, fainting)		
G. Diabetes		
H. Liver disease, (e.g. hepatitis or jaundice)		
I. Arthritis		
J. Stomach disease, (e.g. ulcers)		
K. Intestinal disease, (e.g. polyps)		
L. Kidney disease		

	Y	N
M. Lung disease, (e.g. tuberculosis, pneumonia)		
N. Venereal disease, (e.g. syphilis, gonorrhea)		
O. Blood disease, (e.g. anemia)		
P. Hepatitis A		
Q. Hepatitis B		
R. Tuberculosis (TB)		
S. Chemotherapy (Cancer, Leukemia)		
T. Thyroid Disease		
U. Genital Herpes		
V. Glaucoma		
W. AIDS		
X. Following injury, do you bleed excessively		
Y. Other		

3. **Have you been hospitalized for anything serious** ..... **Yes** **No**
If yes, for what? _____

4. **Are you under the care of a physician** ..... **Yes** **No**
If yes, for what? _____

5. **If female are** you trying to become or are you pregnant, number of months ..... **Yes** **No**

6. **Are you taking any of the following?**

	Y	N
A. Antibiotics or sulfa (e.g. penicillin)		
B. Anticoagulants (blood thinners)		
C. Medicine for high blood pressure		
D. Steroids (cortisone)		
E. Tranquilizers, sedatives		

	Y	N
F. Analgesics (pain killers, aspirin, codeine)		
G. Medication for diabetes		
H. Drugs for heart trouble		
I. Anticonvulsives (e.g. dilantin)		
J. Others		

If so, name and dosage _____

7. **Are you allergic, or have you reacted badly to:**

	Y	N
A. Local anesthetics, (e.g. xylocaine, novocaine)		
B. Penicillin or other antibiotics		
C. Sulfas		
D. Aspirin		

	Y	N
E. Codeine or other narcotics		
F. General anesthesia		
G. Others		

8. **Do you have or have you had any of the following?**

	Y	N
A. Growths, sores, ulcers in or about the mouth?		
B. Burning sensation in the mouth		
C. Bad breath		
D. Bleeding gums		
E. Cold sores		
F. Loose teeth		
G. Change in fit of dentures		

	Y	N
H. Spaces between teeth that bother you		
I. Pain/sensitivity to hot, cold, sweets, pressure		
J. Braces		
K. Gum Surgery		
L. Discolored teeth		
M. Chips or uneven edges on teeth		
N. Other		

9. **Approximate date of last check up:** _____ **Last full mouth X-rays** _____

10. **How often do you brush?** _____ **Floss?** _____ **Were you ever shown?** ..... **Yes** **No**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment.

SIGNATURE _____