**PLEASE PRINT AND FILL OUT COMPLETELY**

PATIENT'S NAME_____ ADDRESS_____ APT #_____

CITY_____ STATE_____ ZIP_____ HM #_____ WK#_____ DOB_____

PATIENT'S SS # _____ SEX _____ MARITAL STATUS _____ EMPLOYER _____

Cell#_____ EMAIL_____ **REFERRED BY**_____

Preferred Contact Method: Calls -- Text -- or Email ?

GUARDIAN(under 18)_____ ADDRESS_____ APT #_____

CITY_____ STATE_____ ZIP_____ HM #_____ WK #_____ DOB_____ CELL

GUARDIAN'S SS #_____ SEX_____ MARITAL STATUS_____ EMPLOYER_____

SUBSCRIBER'S NAME_____ ADDRESS_____ APT #_____

CITY_____ STATE_____ ZIP_____ HM #_____ WK #_____ DOB_____

SUBSCRIBER SS #_____ SEX_____ MARITAL STATUS_____ EMPLOYER_____

INS. CO_____ PLAN NAME_____ INS. PH.#_____ RELATION TO PATIENT_____

MEDICAL HISTORY-Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE (**please circle the EXACT condition**):

| | YES | NO |
|---|---|---|
| 1. Asthma, hay fever, sinusitis, or other allergies | ____ | ____ |
| 2. Allergy to Penicillin, aspirin, local or general anesthetic , or other drugs: specify | ____ | ____ |
| 3. Blood pressure or heart problems/ joint replacements | ____ | ____ |
| 4. Rheumatic fever or heart murmur | ____ | ____ |
| 5. A pacemaker or open heart surgery | ____ | ____ |
| 6. Diabetes, liver, kidney, thyroid, or lung problems | ____ | ____ |
| 7. Ulcers or stomach problems | ____ | ____ |
| 8. Hepatitis or jaundice | ____ | ____ |
| 9. Epilepsy or nervous disorders | ____ | ____ |
| 10. Bleeding or clotting disorders | ____ | ____ |
| 11. Arthritis | ____ | ____ |
| 12. Herpes or canker sores | ____ | ____ |
| 13. Acquired immune deficiency syndrome (HIV or AIDS) | ____ | ____ |
| 14. Any other illness | ____ | ____ |
| 15. Do you smoke or use tobacco products? | ____ | ____ |
| 16. Are you presently taking any medicine?_____ Specify:_____ | | ____ |
| 17. Are you presently under the care of a physician?_____ | | ____ |
| 18. When was your last physical exam?_____ | | |
| 19. Have you ever been hospitalized?_____ Date:_____ Reason:_____ | | |
| 20. Have you had X-ray treatment or chemotherapy? | ____ | ____ |
| 21. Are you presently on a diet? | ____ | ____ |
| 22. Women ( ) Are you taking birth control pills? ( ) Are you pregnant? | | |

Patient Signature Date: Doctor's Signature Date: