Please complete THIS PAGE ONLY. Bring Entire form to your appointment.

Today's Date _____

Name _____ Birth Date _____

Address _____ City _____ Zip _____ Home Ph. _____

Cell Ph. _____ Office Ph. _____ Social Security No. _____

Employer _____ Spouse's Name _____

Spouse's Employer _____ Dental Ins. Co. _____

Name and phone of friend or family member not living with you _____

_____

MEDICAL HISTORY

Please answer the following completely. Your answers are for our records and are considered confidential. This information is necessary for a complete history and diagnosis. Your cooperation is appreciated.

Who is your physician (medical doctor)? _____

Address _____ Phone _____

City and State _____

When did you see her/him? _____ Year _____

Yes No Are you under a physician's care now?
If yes, for what reason _____
When was your last physical? _____

Yes No Do you take aspirin? How much?

Yes No Do you take a blood thinner? (Plavix, Coumadin, Aspirin, Warfarin, etc.)

Yes No Have you ever been told by a physician you have heart trouble?

Yes No Have you been told by a physician you have a heart murmur that requires premedication with an antibiotic?

Yes No Do you have diabetes? Last A1C #_____

Yes No Do you smoke? More than a pack a day? Yes No

Yes No Do you bruise easily?

Yes No Do you have high blood pressure?

Yes No Do you bleed for a long time when you cut yourself?

Yes No Have you experienced an unusual reaction to, or a rash from, penicillin or any other drugs?

Yes No Are you allergic to any medications?

Yes No Are you allergic to latex?

Yes No Has there been any change in your general health in the past year?

Yes No Have you ever experienced an unusual reaction to a dental anesthetic (Novocaine)?

Yes No Are you now anemic?

Yes No Do you get up more than twice a night to go to the bathroom?

Yes No Have you ever had radiation or cobalt treatment to head or neck?
Year _____

Yes No Have you ever had a malignant (cancer) or a non-malignant tumor removed? Year _____

Yes No Do you have more than six drinks or twelve beers a week?

Yes No Have you had any joint replacement? What _____
Approx. When _____

DO YOU OR HAVE YOU EVER HAD:

Yes No Epilepsy or convulsions?
Yes No Glaucoma?
Yes No Tuberculosis?
Yes No Hepatitis?
Yes No AIDS?
Yes No Prolonged bleeding?
Yes No Frequent headaches?

DO YOU HAVE A FAMILY HISTORY OF THE FOLLOWING:

Yes No Stroke
Yes No Diabetes
Yes No Pancreatic Cancer
Yes No Heart Disease
Yes No Alzheimers
Yes No Pre-eclampsia
Yes No Premature Birth

HAVE YOU EVER TAKEN:

Yes No Drugs for sleep?
Yes No Anticoagulants?
Yes No Nitroglycerin?
Yes No Drugs for high blood pressure?
Yes No Cortisone, steroids?
Yes No Tranquilizers or sedative?
Yes No Insulin or drugs for diabetes?
Yes No Drugs for heart trouble?
Yes No Do you take drugs for osteoporosis?

WOMEN

Yes No Are you taking birth control pills?
Yes No Are you pregnant?
Yes No Have any of your babies weighed more than 10 pounds at birth?

List any medication you are presently taking or have taken in the previous year _____

_____

List any over the counter medications (aspirin, St. John's Wort, vitamins, etc.) _____

_____

To the best of my knowledge the above information is complete and accurate. I understand I am responsible for all expenses charged for treatment in this office. By signing this form you will consent to our use and disclosure of your health information to carry out treatment, payment activities and health care operations. You also have the right to request a copy of our Notice of Privacy Practices before signing this form.

Patient's Signature _____ Date _____
(Parent if patient is under 18 years of age.)