Welcome to our office. Fees are expected to be paid at time of service. Any other arrangements must be made in advance of actual treatment.
Thank you for coming to our office.

1. Date:________________ Name:____ Date of Birth: _______ Age: ____
2. Address:____ Telephone:________________
3. Patient's Social Security Number:________________________________ Marital Status:________
4. Patient's Place of Employment: ________________ Work # ________________
5. Spouse's Name and Place of Employment:________________ Work # ________________
6. Spouse's Social Security Number:________________________________ Phone: ____________
7. Person Responsible for Payment:________________________________ Address:________________
8. Do you have dental insurance?____________ Insurance Co.: ________________________
9. Reason for your visit today:____
10. Whom may we thank for referring you: ________________________________
11. Your physician's Name and Phone Number:________________________________

DIRECTIONS:

Answer all questions by circling either YES or NO and fill in the blank spaces to the best of your ability. All information will be considered confidential. **IF YOU DON'T UNDERSTAND A QUESTION, PLEASE ASK.**

1. Date of your last physical examination:________________________
2. Have you been hospitalized or had a serious illness within the last 3 years? .... Yes No
   If so, what was the problem? ____
3. Are you under the care of a physician? .... Yes No
   If so, for what condition?____
4. Do you have or have you had any of the following diseases or problems:

5 Hip or Joint Replacement Yes No

A. CARDIOVASCULAR:
1) Rheumatic Fever .... Yes No
2) Congenital Heart Defect - type:________________ surgery date:________________ .... Yes No
3) Angina Pectoris - frequency:________________ .... Yes No
4) Myocardial Infarction (Heart Attack) - date:________________ .... Yes No
5) Arrhythmias (Irregular Beat) - type:________________ .... Yes No
6) Cardiac Murmur - etiology (cause):________________ .... Yes No
7) Congestive Heart Failure - date:________________ .... Yes No
8) Heart Surgery - type:________________ date:________________ .... Yes No
9) Pacemaker Implanted - type:________________ date:________________ .... Yes No
10) Hypertension (High Blood Pressure) - BP:________/________ .... Yes No
11) Hypotension (Low Blood Pressure) - BP:________/________ .... Yes No
12) Stroke (CVA) - date:________________ .... Yes No
13 Mitral Valve Prolapse (MVP) Yes No

B. RESPIRATORY DISEASES:
1) Asthma - severity:________________ .... Yes No
2) Emphysema - severity:________________ .... Yes No
3) Bronchitis - severity:________________ .... Yes No
4) Hay Fever or Sinusitis .... Yes No

C. ENDOCRINE DISORDERS:
1) Diabetes - type control: .... Yes No
2) Hyperthyroidism (High Thyroid) - treatment:________________________ .... Yes No
3) Hypothyroidism (Low Thyroid) - treatment:________________________ .... Yes No

D. HEMATOLOGIC (BLOOD) DISORDERS:
1) Anemia - type:________________ .... Yes No
2) Bleeding Tendency - Do you bruise easily or bleed excessively when cut? .... Yes No
   Explain: ____

(Complete Reverse Side)

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E. INFECTIOUS DISEASES:

1) Hepatitis - type:__________ date:__________ .... Yes No
2) Veneral Disease - type:__________ date:__________ .... Yes No
3) Tuberculosis - date:__________ .... Yes No
4) AIDS - date:__________ .... Yes No

F. RENAL (KIDNEY) DISEASE:

1) Have you had any kidney infections within the last 3 years? .... Yes No
   type:__________ date:__________
2) Have you had any kidney surgery? type:__________ date:__________ .... Yes No

G. MISCELLANEOUS DISEASES OR DISORDERS:

1) Syncope (Fainting) - frequency:__________ .... Yes No
2) Liver Disease - type:__________ .... Yes No
3) Arthritis - type:__________ .... Yes No
4) Ulcers - type:__________ .... Yes No
5) Glaucoma: .... Yes No
6) Radiation Therapy - type:__________ date:__________ .... Yes No
7) Epilepsy - treatment:__________ .... Yes No
8) Have you had cancer? - type:__________ date:__________ .... Yes No
9) Do you use tobacco? - type:__________ .... Yes No

5. Are you taking any of the following medications:

A. Antibiotics (etc.) - type:__________ amount:__________ .... Yes No
B. Anticoagulants (Blood Thinners) .... Yes No
C. Steroids (Cortisone) - type:__________ amount:__________ .... Yes No
D. High Blood Pressure Medicine - type:__________ amount:__________ .... Yes No
E. Tranquilizers - type:__________ amount:__________ .... Yes No
F. Aspirin - how often:__________ .... Yes No

Others:	**Drug**	**Amount**	**How Often**
G.			
H.			

6. Do you have an allergy or reaction to:

A. Local Anesthetics - type:__________ reaction:__________ .... Yes No
B. Penicillin or Antibiotics - type:__________ reaction:__________ .... Yes No
C. Sulfa Drugs - reaction:__________ .... Yes No
D. Aspirin - reaction:__________ .... Yes No
E. Barbiturates or Other Sedatives - type:__________ reaction:__________ .... Yes No

Others .... **Drug** .... **Reactions** .... Yes No

F.__________

7. Have you had difficulty with any dental treatment including extractions? .... Yes No
   If so, explain:__________
8. Do you have any problem or condition not listed above? .... Yes No
   If so, explain: ....

9. **WOMEN ONLY:**

1) Are you pregnant? - scheduled delivery:__________ .... Yes No

PLEASE CHECK YOUR METHOD OF PAYMENT TODAY:

- ☐ CASH
- ☐ CHECK
- ☐ VISA/MASTERCARD
- ☐ DISCOVER

The information on both sides of this page is correct:

____
Signature of Patient or Parent-Guardian