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)

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