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Patient's Name: ______________________ Birth Date: ______________

Patient's Home Address: ______________________ Home Phone: ______________

City and Zip: ______________________ Work Phone: ______________

Place of Employment: ______________________ Cell Phone: ______________

Name of Spouse: ______________________ Where Employed: ______________

Person Responsible for Patient's Account: ______________________

Name of Dental Insurance Company: ______________________

In Case of Emergency Contact: ______________________ Phone: ______________

Name of Dentist Who Referred You: ______________________

HEALTH HISTORY

Name of Physician: ______________________ Date of Last Physical: ______________

Please check (✓) any of the following diseases or problems which you have or have had:

- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Heart Trouble
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Asthma or Hay Fever
- ☐ Epilepsy (fainting spells or seizures)
- ☐ Thyroid Condition or Goiter
- ☐ Stomach Ulcers
- ☐ Kidney Trouble
- ☐ Emotional Difficulty
- ☐ Venereal Disease
- ☐ HIV infection/AIDS
- ☐ Sinus Trouble
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Stroke
- ☐ Angina
- ☐ Diabetes
- ☐ Arthritis
- ☐ Allergies
- ☐ Tuberculosis
- ☐ Hives or Skin Rash
- ☐ Joint Replacement

Please check (✓) Yes or No for each question:

☐ Yes ☐ No 1. Are you in good health?
☐ Yes ☐ No 2. Are you under a physician's care?
☐ Yes ☐ No 3. Have you been hospitalized or had a serious illness within the last five years?
☐ Yes ☐ No 4. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
☐ Yes ☐ No 5. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or body?

6. Have you had any of the following within the last 6 months?

☐ Yes ☐ No Antibiotics or Sulfa Drugs
☐ Yes ☐ No Anticoagulants (blood thinners)
☐ Yes ☐ No Medicine for Blood Pressure
☐ Yes ☐ No Cortisone Steroids
☐ Yes ☐ No Tranquilizers
☐ Yes ☐ No Nitroglycerin, or other Drugs for Heart Trouble
☐ Yes ☐ No Insulin or Oral Medication for Diabetes
☐ Yes ☐ No Medication for Osteoporosis
☐ Yes ☐ No Other Medication? ______________

7. Are you ALLERGIC to any of the following?

☐ Yes ☐ No Local Anesthetics
☐ Yes ☐ No Penicillin or other Antibiotics
☐ Yes ☐ No Barbiturates, Sedatives or sleeping pills
☐ Yes ☐ No Aspirin or Codeine
☐ Yes ☐ No Iodine or Latex
☐ Yes ☐ No Other? ______________

8. Women are you:

☐ Yes ☐ No Pregnant
☐ Yes ☐ No Breastfeeding
☐ Yes ☐ No Using Oral Contraceptives or hormonal therapy

9. Do you have any other disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

Explain: ______________________

I certify that I have accurately answered the above questions to the best of my knowledge. I consent to the performance of dental procedures agreed to be necessary including the use of local anesthetic as indicated, and I will assume responsibility for fees with those procedures.

Signature: ______________________ **SS#** ______________ **Date:** __________