ANSWERS TO ALL QUESTIONS ARE FOR OFFICE USE AND STRICTLY CONFIDENTIAL

Date ______________

Patient ________________________________ Home # ______________

Address ______________________ City ______________ Zip ________

E-mail Address ____

Sex: M _____ F _____ Age _______ Birthdate ______________ Marital Status S M W D

Employed By ______________________ Occupation ______________

Business Address ______________________ Business Phone ______________

Spouse Name ______________________ Business Phone ______________

Spouse Employed By ______________________ Occupation ______________

Who is responsible for account? ________________________________

Soc. Sec. # ______________ Spouse Soc. Sec. # ______________ Birthdate ______________

Dental Insurance Co. ______________________ Subscriber ______________

Insurance ID# ______________________ Group # ______________

Nearest Friend or Relative (Name & Phone#) ________________________

Previous General Dentist (Name, Address, Phone #) ________________________

____

MEDICAL HISTORY

1. Medical doctor (Name, Address, Phone#) ________________________

____

2. Are you under a doctor's care now? Why? ______________________ Yes No
3. Have you been hospitalized during the past two years? Why? ______________________ Yes No

   ____

4. Are you taking any medications, pills, or drugs? What? ______________________ Yes No

   ____

5. Are you allergic to any medication or substance? What? ______________________ Yes No

   ____

6. Are you pregnant? (women) ______________________ Yes No

MARK AN X IN THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING:

❑ Heart Trouble	❑ Chest Pain	❑ Scarlet Fever	❑ Cancer	❑ Hypoglycemia
❑ High Blood Pressure	❑ Shortness of Breath	❑ Asthma	❑ Thyroid Disease	❑ Psychiatric Care
❑ Low Blood Pressure	❑ Swelling of Feet\Ankles\Hands	❑ Hay Fever	❑ Parathyroid Disease	❑ Drug Addiction
❑ Heart Murmur	❑ Fainting or Dizziness	❑ Sinus Trouble	❑ X-ray or Cobalt Tmt.	❑ Blood Transfusion
❑ Rheumatic Fever	❑ Stroke	❑ Emphysema	❑ Chemotherapy\Radiation	❑ Hemophilia
❑ Congenital Heart Lesion	❑ Diabetes	❑ Frequent Cough	❑ Arthritis\Gout	❑ AIDS\HIV
❑ Artificial Heart Valve	❑ Excessive Thirst	❑ Lung Disease	❑ Rheumatism	❑ Venereal Disease
❑ Heart Pacemaker	❑ Artificial Joints\Hips	❑ Tuberculosis	❑ Pain in Jaw Joints	❑ Cold Sores
❑ Heart Surgery	❑ Kidney Trouble	❑ Liver Disease	❑ Cortisone Medicine	❑ Fever Blisters
❑ Blood Disease	❑ Ulcers	❑ Hepatitis A (infec.)	❑ Glaucoma	❑ Herpes
❑ Anemia	❑ Allergies	❑ Hepatitis B (serum)	❑ Epilepsy or Seizures	❑ Bruise Easily
❑ Yellow Jaundice	❑ Nervousness	❑ Sickle Cell Anemia		

7. Have you ever had any other serious illness or condition not marked above? ______________ Yes No

   Describe in detail ____

8. Do you wish to talk to the doctor privately about any problem? ______________ Yes No