Name_____

Address_____

City _____ Zip Code_____

Phone _____ Birth date_____

Who will pay for this account?_____

Who may we contact in case of emergency?

_____

Medical doctor_____

Pharmacy Preference_____

Employer_____

Primary Dental Insurance Co. _____

Group #_____

Employee_____

Secondary Dental Insurance Co_____

Group#_____

Employee_____

Please list any prescription and over the counter Medications that you take on a regular basis

Please circle Yes or no to indicate if you have had any of the following conditions:

Yes	No	High or low Blood pressure	Yes	No	Ulcers
Yes	No	Congenital Heart Defect	Yes	No	Cold sores
Yes	No	Heart Murmur	Yes	No	AIDS
Yes	No	Pace maker or Internal Defibrillator	Yes	No	HIV Positive
Yes	No	Artificial Heart Valve	Yes	No	Abnormal Bleeding
Yes	No	Cardiac Stent	Yes	No	Cancer or Leukemia
Yes	No	Heart Attack	Yes	No	Radiation Therapy
Yes	No	Chest Pains	Yes	No	Chemotherapy
Yes	No	Rheumatic Fever	Yes	No	Organ Transplant
Yes	No	Arthritis	Yes	No	Stroke
Yes	No	Osteoporosis or bone disorders	Yes	No	Epilepsy or Seizures
Yes	No	Medications for Osteoporosis or bone disorders	Yes	No	Frequent headaches
Yes	No	Artificial Joint, Pin or Implant	Yes	No	Migraine Headache
Yes	No	Antibiotics before Dental Treatment	Yes	No	Blood Thinners or Aspirin
Yes	No	Tuberculosis	Yes	No	Unexplained Fever
Yes	No	Asthma	Yes	No	Sinus Trouble

Yes	No	Frequent Cough	Yes	No	Prolonged Sore Throat
Yes	No	Liver Disease	Yes	No	Swollen Lymph Nodes
Yes	No	Hepatitis or Jaundice	Yes	No	Fainting
Yes	No	Spleen Removal	Yes	No	Tobacco Use
Yes	No	Kidney Problems	Yes	No	Substance Abuse
Yes	No	Diabetes	Yes	No	Allergies to Drugs or Medications
Yes	No	Thyroid Condition	**If Yes, Please list below**		

_____

Please list any condition or illness not listed above?

Are you Pregnant? Yes No Due Date_____

Are you taking birth control pills Yes No

Yes No Have you ever been told you have gum disease?

Yes No Do you clench or grind your teeth?

Yes No Do you have difficulty opening your mouth wide.

Yes No Is there anything you would like to change about the look or feel of your teeth? If yes, please Explain:

Signature/Date

_____

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Signature/Date

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