ABOUT

Name_____ I prefer to be called _____ ( ) Male ( ) Female

( ) Single ( ) Married ( ) Child ( ) Other Birth date: _____ Social Security #_____

Home Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____

I prefer my appointments to be confirmed via: ( ) Home ( ) Work ( ) Cell ( ) E-mail

Employer: _____ Occupation:_____

Employer's Name: _____ City: _____ State: _____ Zip: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name_____ Birth date: _____ Relation:_____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ S.S.# _____

Employer: _____ Occupation:_____

DENTAL INSURANCE INFORMATION

Insured Co. Name _____ Phone: ( )_____ Group #_____

Insured's Name: _____ Insured's Birth Date: _____ Relation:_____

Insured's Social Security #:_____ Insured's Employer: _____

We are committed to excellence in dentistry and appreciate you taking the time to complete the confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help you.

Whom may we thank you for referring you? _____

PERSONAL HISTORY

Name: _____ Age _____ Birth Date _____ Sex M / F Wt: _____ Telephone: _____

Family Physician:_____ Telephone: _____

In Case of Emergency Notify: _____ Telephone: _____

CURRENT HEALTH HISTORY

Reason for today's visit: _____

PAST MEDICAL HISTORY

1. Are you in good health now?	Y	N	7. Are you allergic to latex or any drug or medication?	Y	N
2. Any change in health during the past year?	Y	N	8. Have you ever been admitted to the hospital?	Y	N
3. Have you ever had any serious illness?	Y	N	9. Have you ever had surgery?	Y	N
4. Last physical examination _____	Y	N	10. Have you ever had a general anesthesia?	Y	N
5. Are you under the care of a physician now?	Y	N	11. Have you ever had plastic surgery?	Y	N
6. Are you taking medication now?	Y	N			

_____

_____

SOCIAL AND FAMILY HISTORY

1. Single / Married / Divorced

2. Do you smoke?	Y	N	yrs: _____ pks/day:_____	
3. Do you drink?	Y	N	how much _____	
4. Birth control?	Y	N	type:_____	
5. Pregnancy?	Y	N	last menses _____	
6. STD?	Y	N		

7. Occupation: _____

8. Family Health: (children, mother, father)

Father:_____

_____

Mother: _____

_____

_____

REVIEW OF SYSTEMS

Heart Disease			**Vascular Disease**		
1. Heart Disease or Heart Attach	Y	N	9. High cholesterol or HDL	Y	N
2. Chest pain or Angina Pactoris	Y	N	10. High or low blood pressure	Y	N
3. Congenital heart condition / defect	Y	N	11, Stroke or TIA (transient ascemic attacks)	Y	N
4. Heart murmur/Funct MVP/Pneumatic HD	Y	N	12. Thrombophlebitis, DTV (deep vein thrombosis)	Y	N
5. Heart surgery / CABG____Valve ___Other___	Y	N	13. Blood disorder / anemia / hemophilia / leukemia	Y	N
6. Heart failure / SOB/ankles swelling	Y	N	14. Have you ever had a blood transfusion?	Y	N
7. Heart palpitations or arrhythmias	Y	N	15. Do you bruise easily or bleed more than normal?	Y	N
8. Passing out or faining	Y	N	16. Are you taking any blood thinning medication?	Y	N
			17. Are you taking aspirin frequently?	Y	N

RESPIRATORY AND LUNG DISEASE

1. Sinus or allergy	Y	N	**OTHER DISORDERS**		
2. Asthma	Y	N	13. Stomach ulcers or bowel disorders	Y	N
3. Bronchitis or chronic cough	Y	N	14. Liver disease, hepatitis / cirrhosis	Y	N
4. Emphysema	Y	N	15. Kidney or urinary tract disorder	Y	N
5. Pneumonia or other infections	Y	N	16. Lupus or other connective tissue disease	Y	N
6. Tuberculosis or cough up blood	Y	N	17. Arthritis: Osteo / Rheumatoid / Gout	Y	N
SPECIAL SENSES			18. Osteoporosis	Y	N
7. Hearing loss	Y	N	19. Cancer - Where? _____	Y	N
8. Vision disorder / cataract / glaucoma	Y	N	20. Depression or other psychological disorder	Y	N
9. Wear glasses / contact lenses	Y	N	21. Eating disorder: Anorexia / Bulimia	Y	N
ENDOCRINE DISORDER			22. Weight loss diet - Medication _____	Y	N
10. Diabetes I II Insulin Other medicine	Y	N	23. Seizures or epilepsy	Y	N
11. Thyroid disorder	Y	N	24. Parkinson's / other motor system disorder	Y	N
12. Adrenal disorder / taking steroids	Y	N	25. Drug addiction	Y	N

TEMPOROMANDIBULAR JOINT-FACIAL PAIN

1. Do you have TMJ?	Y	N	3. Do you have facial pains?	Y	N
2. Do your joint(s) pop or click?	Y	N	4. Do you suffer from frequent headaches?	Y	N

Patient Signature Date Staff Initial Dr. Initial

*Please complete information on back of form****

I have read my MEDICAL HISTORY dated _____ and confirm that it states past and present conditions.

Date Exceptions: Patient's Signature

_____ _____ _____

_____ _____ _____