PERSONAL INFORMATION of ______________________________ Date __________

This personal information will help us to give you the most consideration of your time and feelings. It is important to have complete answers. All information is, of course, confidential.

Are you aware of any particular dental problems? ______________________________

____

Are you having any discomfort or pain? ______________________________

How long has it been since you last visited a dental office? ______________________________

Previous Dentist ______________________________

What was done for you at this time? ______________________________

May we ask who recommended this office? ______________________________

Your name: ______________________________

Home address: ______________________________

Home phone: ____________ Occupation? ____________ Social Security. # ____________

Emergency Contact No. ______________________________

For what company do you work? ______________________________

Phone: ____________ Ext: ______ Cell Phone: ____________

Are you covered by any kind of dental insurance? Yes ☐ No ☐ Insured's Name ____________

If so, what insurance. ____________ Insured Social Security # ____________

If married, occupation of your husband/wife ______________________________

For what company does your husband/wife work? ____________ Phone ____________ Ext: ______

Is you husband/wife covered by any kind of dental insurance? Yes ☐ No ☐

If so, what insurance?: ____________ Insured Social Security # ____________

Full time or part time student ____________ Name of college ____________

Your physician's name: ____________ Address: ____________

DATE	DOCTOR'S NOTES AND UP-DATES ON PERSONAL INFORMATION

HEALTH HISTORY

Has there been any problem in your general health within the past 5 years? (Serious illness, hospitalization, surgery) Yes ☐ No ☐

If so, what was the problem? ______________________________

Have you had any form of cancer? Yes ☐ No ☐ If so, what type or name? ______________________________

Date of last medical check-up ______________ Attending physician ______________________________

Date of last blood test ______________ Attending physician ______________________________

Under a physician's care now? Yes ☐ No ☐ If so, for what? ______________________________

What tablets, pills or liquids do you take? (that includes aspirin, vitamins, tonics, etc.) ______________________________

____

Does your physician require you to take special medication before dentistry? Yes ☐ No ☐ If so, what? ______________

____

Date and year of birth: ______________ Husband's (or wife's) date and year of birth: ______________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	YES	NO
Rheumatic fever, rheumatic heart disease	☐	☐
Heart trouble, heart attack	☐	☐
Heart Stent in past 3 months	☐	☐
High blood pressure, stroke	☐	☐
Heart murmur, mitral valve prolapse	☐	☐
Pain in chest, shortness of breath, swollen ankles	☐	☐
Blood disorders, anemia	☐	☐
Cold sores or herpes incident	☐	☐
Positive test for venereal disease within five years	☐	☐
Positive test for AIDS virus	☐	☐
Abnormal bleeding, prolonged healing, bruises easily	☐	☐
Asthma, hay fever	☐	☐
Low blood pressure	☐	☐
Fainting spells, seizures	☐	☐
Hepatitis, jaundice, liver disease	☐	☐
Arthritis	☐	☐
Have you had an orthopedic joint replacement	☐	☐
Have you had an organ transplant	☐	☐
Kidney troubles	☐	☐

	YES	NO
Tuberculosis, other lung ailments	☐	☐
Persistent cough, cough up blood	☐	☐
Diabetes	☐	☐
Radiation treatment for a tumor or other growth	☐	☐
Sores that did not heal within one week	☐	☐
Women: Are you pregnant	☐	☐
Do you use tobacco products	☐	☐
Are you sensitive or allergic to: Penicillin	☐	☐
Codeine	☐	☐
Novocaine	☐	☐
Aspirin	☐	☐
Other anesthetics	☐	☐
Other drugs	☐	☐
Do you have any disease, condition or problem not listed above that you think the doctor should know about?	☐	☐

____

______________________________ ______________

Patient's Signature Date