This personal information will help 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 the dentist?_____
What was done for you at that time?_____

Name_____SS#_____ Home Phone_____
Address_____City_____State_____Zip_____
Occupation_____Employer_____Work Phone_____
Email_____ Cell Phone_____

First name of spouse or parent_____SS#_____Birthdate_____
Occupation_____Employer_____Work Phone_____

Dental Ins Co_____ID#_____Group#_____
Physician's name_____Address_____Phone_____

Date of Birth_____Marital Status_____

How did you find out about our office. Advertisement_____Referral_____By Whom?_____

Health History

Have there been any problems in your general health within the past 5 years?_____
List the nature of the problem_____
Date of your last medical exam_____Are you under a Doctors care at this time?_____
List any medications you are taking at this time_____
_____

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

Rheumatic Fever	yes___no___	Low Blood Pressure	yes___no___
Rheumatic Heart Disease	yes___no___	Kidney Problems	yes___no___
Chest Pains	yes___no___	Tuberculosis	yes___no___
Diabetes	yes___no___	Liver Disease	yes___no___
Radiation	yes___no___	Anemia	yes___no___
Asthma	yes___no___	Hay Fever	yes___no___
Blood Disorders	yes___no___	Seizures	yes___no___
Heart Attack	yes___no___	Hepatitis	yes___no___
High Blood Pressure	yes___no___	Jaundice	yes___no___
Stroke	yes___no___	Arthritis	yes___no___
Sores that don't heal	yes___no___	Persistent Cough	yes___no___
WOMEN Are you Pregnant	yes___no___	Due Date_____	
Cough up Blood	yes___no___	Do you use tobacco	yes___no___
AIDS/HIV	yes___no___		

Allergies

Aspirin	yes___no___	Penicillin	yes___no___
Anesthetic	yes___no___	Codeine	yes___no___

Please list any other allergies:_____
Do you have any disease, condition or problem not listed above?_____

Date_____Signature_____