PATIENTS GENERAL INFORMATION AND MEDICAL HISTORY

Patient's Name:_____________________________________ Date of Birth:_______________

Spouse/Partner or Parent Name:____

Home Address:____ Apt:___________________

City:________________________ Zip:_____________ Cell Phone:________________________

Home/Work Phone:________________________ Patient's SSN:_________________________

Insured Employer:___________________________ Employer Phone:_____________________

Dental Insurance Company, If any:____

Insured Name:___________________________________ Insured Date of Birth:____________

Dental Insurance ID#:________________________ Insured SSN:_________________________

Are you under the care of a physician? Yes No
Are you taking any medication or pills of any kind? Yes No
If so, list below:____

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Do you require antibiotic premedication prior to dental procedures? Yes No

Are you allergic to any of the following?

Penicillin	Yes No	Iodine/Seafood	Yes No	Barbiturates	Yes No
Aspirin	Yes No	Bleach	Yes No	Local Anesthetic (novocaine)	Yes No
Codeine	Yes No	Latex	Yes No		

Other Allergies:____

Have you ever had any of the following?

Rheumatic Fever	Yes No	Artificial Joints	Yes No
High or Low Blood Pressure	Yes No	Bleeding Tendencies	Yes No
Cardiac Condition	Yes No	Kidney Condition	Yes No
Heart Murmur	Yes No	Liver Disease	Yes No
Pacemaker	Yes No	Ulcer Condition	Yes No
Asthma	Yes No	Major Operation	Yes No
Diabetes	Yes No	Psychiatric Condition	Yes No
Arthritis	Yes No	Seizures	Yes No
Tuberculosis	Yes No	Thyroid Condition	Yes No
Hepatitis	Yes No	Migraine	Yes No
Venereal Disease	Yes No	Aids/HIV	Yes No
Respiratory Condition	Yes No	Are you currently pregnant?	Yes No

Month_______________________

Is there any other information about your health that we should know? Yes No
If so, please state below...

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I acknowledge all information provided here is accurate and reliable
Patient/Guardian Signature: ____ Date: _____________
Reviewed by: ____ Date: _____________