Reason for Visit :_____Date of last Dental Visit:_____

Have you ever had any of the following? Please check those that apply:

AIDS / HIV	Growths	Respiratory Problems
Allergies	Hay Fever	Rheumatic Fever
_____	Head Injuries	Rheumatism
Anemia	Heart Disease	Sinus Problems
Arthritis	Heart Murmur	Stomach Problems
Artificial Joints	Hepatitis	Stroke
Asthma	High Blood Pressure	Tuberculosis
Blood Disease	Jaundice	Tumors
Cancer	Kidney Disease	Ulcers
Diabetes	Liver Disease	Venereal Disease
Dizziness	Mental Disorders	Codeine Allergy
Epilepsy	Nervous Disorders	Penicillin Allergy
Excessive Bleeding	Pacemaker	Other:
Fainting	Pregnancy/due date_____	_____
Glaucoma	Radiation Treatment	_____

Have you ever had any complications following dental treatment? yes no

If yes, please explain:_____

Have you ever been admitted to a hospital or needed emergency care during the past two yrs?

If yes, please explain:_____

Are you now under the care of a physician? Yes No

If yes, please explain:_____

Name of Physician:_____Phone #:_____

Do you have any health problems that need further clarifications? Yes No

If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? another patient, friend another patient, relative
Yellow Pages Internet Work Brochure Insurance Location Other

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered a copy of this office's Notice of Privacy Practices.
(Please Print Name)

_____
Signature Date

_____
Doctor Signature Date