

Reason for Visit: _____ Date of last Dental Visit: _____

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

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS /HIV | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatism |
| _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> BLOOD THINNERS |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy/ due date _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Growths | <input type="checkbox"/> 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 years?

If yes, please explain: _____

Are you currently under the care of a physician? Yes No **Do you take any medications?** 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 list: _____

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? Name of patient, friend, 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 _____