Health History

Mr. Mrs. Miss _____ Birthdate _____ Age _____ Soc. Sec. No _____

Home Address _____ City _____ Zip _____ Phone Number _____

Person Financially Responsible _____ Relationship to you _____ Soc. Sec. No _____

Occupation _____ Employer _____ Phone Number _____

Dental Insurance _____ Group or Plan No _____ Referred By _____

Spouse Name _____ Birthdate _____ Employer _____ Soc. Sec. No _____

Person to contact in case of Emergency - Name _____ Phone Number _____

Medical History

Physician _____ Address _____ Phone Number _____

Are you in good health? _____ If no, explain _____

Do you have an existing illness? _____ If yes, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

Are you taking any medication, pills, or drugs? _____ If yes, please list: _____

Do you now have, or have you had any of the following? (If yes, describe under remarks.)

	YES	NO		YES	NO
1. Heart Disease	☐	☐	13. Liver Disease	☐	☐
2. High Blood Pressure	☐	☐	14. Kidney Disease	☐	☐
3. Blood Disease	☐	☐	15. Hepatitis	☐	☐
4. Rheumatic Fever	☐	☐	16. Asthma	☐	☐
5. Heart Murmur	☐	☐	17. Tuberculosis	☐	☐
6. Diabetes	☐	☐	18. AIDS or HIV positive	☐	☐
7. Stroke	☐	☐	19. Allergy to: (a) Penicillin	☐	☐
8. Epilepsy	☐	☐	(b) Other Anesthetics	☐	☐
9. Arthritis	☐	☐	(c) Local Anesthetics	☐	☐
10. Tumor History	☐	☐	(d) Other	☐	☐
11. VD	☐	☐	20. Are you Pregnant?	☐	☐
12. Radiation Treatment	☐	☐			

Dental History

Do you have any present dental complaints? _____ Where? _____

When was your last full mouth X-ray taken? _____ Where? _____

When was your last cleaning? _____

Have you ever been instructed in the prevention of decay? _____

Have you ever been instructed in caring for your gums? _____

Remarks

_____

_____

I consent to whatever Dental Procedures and anesthetics are necessary for the treatment of the above named patient.
I also agree to assume full Financial Responsibility for all treatment rendered.

Signature _____ Date _____