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Patient Name _____ Age _____ Birthdate _____
(last) (first)

Sex: Male Female Single Married Minor Other _____

If patient is a minor, parent or guardian's name _____ Relationship _____

Name you would like to be addressed as _____ E-mail address: _____

Home Address _____ Home Phone () _____

City _____ State _____ Zip Code _____

Driver's License # _____ Social Security # _____

Employed By _____ Occupation _____

Work Phone () _____ Cellular Phone () _____

Spouse's Name _____ Social Security # _____

Spouse's Employer _____ Occupation _____

Emergency Contact _____ Relationship _____

Complete Address _____ Phone () _____
Street City Zip Code

Former Dentist _____ Last Visit _____

How did you hear about us? Friend/Co-worker/Relative Walk-by/Drive-by Internet Other: _____

Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Insurance Company	Insurance Company
Billing Address	Billing Address
City State Zip Code	City State Zip Code
Insurance Phone # Group #	Insurance Phone # Group #
Name of insured Relationship to Pt	Name of Insured Relationship to Pt
Social Security# or ID# Birthdate	Social Security# or ID# Birthdate

(continued on reverse)

HEALTH HISTORY

Patient Name: _____ Birth Date: _____

E-mail Address: _____

Medical Doctor Name _____ Phone # _____

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

If yes, for what? _____ Date of Last Exam _____

Have you been hospitalized or had a serious illness within the past 5 years? Yes No

If yes, please explain _____

Are you currently taking or have ever taken in the past:

Bone density meds or Bisphosphonates: Aredia, Zometa, Fosamax, Actonel or other: _____

Blood thinners: Coumadin, Aspirin or other: _____

Weight loss medications/Diet pills: Fen-phen, Meridia, Xenical, Acomplia or other: _____

Please list all medications you are taking and the reason (including over the counter medications and recreational drugs):

Are you allergic to or have you reacted adversely to any of the following medications? Circle if yes.

PENICILLIN	ERYTHROMYCIN	SULFA DRUGS	LATEX
IBUPROFEN	ASPIRIN	VICODIN	CODEINE
			LOCALANESTHETIC

Are you aware of being allergic to any other medication or substance not listed?

Have you ever had an adverse skin reaction to metals? If yes, list types of metals: _____

Have you ever had any of the following? Circle yes or no:

yes	no	High Blood Pressure	yes	no	Asthma
yes	no	Heart Murmur	yes	no	Sinus Trouble
yes	no	Mitral Valve Prolapse	yes	no	Hepatitis
yes	no	Heart Disease	yes	no	Tuberculosis
yes	no	Rheumatic Fever	yes	no	Diabetes
yes	no	Metal Pins or Plates	yes	no	Epilepsy
yes	no	HIV/AIDS	yes	no	Bleeding Problems
yes	no	Artificial Joint Placed	yes	no	Tobacco in any form

Do you have any disease, condition or problem not listed above? If yes, explain: _____

Have you ever had problems with prior dental treatment? _____

FOR WOMEN ONLY: Are you pregnant? yes no If yes, due date: _____

CONSENT FOR TREATMENT

The above is true and correct to the best of my knowledge. If I ever have a change in my health, I will inform the doctor of that change without fail. I authorize a complete examination, radiographs, cleaning, and other treatment considered necessary, including the use of local anesthesia and medications that may be indicated.

Patient Signature: _____ Date: _____ Dr. Signature: _____

HEALTH HISTORY UPDATE

I have reviewed the original health history above and certify that it is accurate except for the changes indicated below:

Date	Changes	Patient Signature	Dr. Signature