

ABOUT YOU

Name: _____

I prefer to be called: _____

Male Female

Birthdate: _____ SS# ____ - __ - ____

Home Address: _____

City _____ State _____ Zip _____

Single Married Divorced Widowed

Home Phone: _____

Work Phone: _____ Ext. _____

E-mail Address: _____

Our goal is to help you reach and maintain maximum dental health. Please fill out this form as completely as you can. Upon review make any changes necessary (initial & date each change, please) and sign below. Thanks.

Signature of Patient,
Parent or Guardian _____

Date _____

UPDATE ONE

Signature of Patient,
Parent or Guardian _____

Date _____

UPDATE TWO

Signature of Patient,
Parent or Guardian _____

Date _____

UPDATE THREE

Signature of Patient,
Parent or Guardian _____

Date _____

MEDICAL HISTORY UPDATE

Do you have a personal physician? Yes No

Physician's Name: _____

Date of last visit: _____

Are you currently under his/her care? Yes No

If Yes, for what condition? _____

Do you now or have you used tobacco? Yes No

Do you take vitamins? Yes No

Are you taking ANY medications? Yes No

Please list each one _____

Have you ever had any of the following diseases or medical problems?

Y N Anemia / Hemophilia Y N Asthma / Hay Fever Y N Arthritis Y N Artificial Bones / Joints Y N Artificial Valves Y N Cancer-Date _____ Y N Diabetes Y N Drug / Alcohol Abuse Y N Ear / Nose / Sinus Y N Emphysema / TB Y N Epilepsy Y N Esophageal Refex	Y N Fever Blister/Cold Sore Y N Heart Attack / Stroke Y N Heart Murmur Y N Heart Problem Y N Hepatitis/Liver Disease Y N High Blood Pressure Y N HIV+ / AIDS Y N Mitral Valve Prolapse Y N Rheumatic Fever Y N Severe/Freq. Headache Y N Stomach / Intestinal Y N Thyroid
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Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y N Penicillin Y N Aspirin Y N Erythromycin	Y N Tetracycline Y N Dental Anesthetics Y N Codeine	Y N Latex Y N Sulfa Other: _____
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FOR WOMEN Are you pregnant? Yes No

Do you take birth control pills? Yes No

Are you nursing? Yes No