Patient Name: ______________________________ Date: ______________

Address: ____________________________________________________________
Street City State Zip Code

Phone (home): (____)______________ (Cell): (____)______________ E-Mail: ______________________

Birth Date: ______________ Social Security #: ____________________ Family Status: ______________ Gender: _______

Emergency Contact: ____________________ Phone: (____)______________ Relationship: ____________________

## Health Information

**Please Check (☑) "yes" or "no" to indicate if you have had any of the following:**

| Yes | No | Condition |
|---|---|---|
| ☐ | ☐ | AIDS |
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Arthritis, Rheumatism |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Back Problems |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Chemical Dependency |
| ☐ | ☐ | Chemotherapy |
| ☐ | ☐ | Circulatory Problems |
| ☐ | ☐ | Cortisone Treatments |
| ☐ | ☐ | Cough – persistent/bloody |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Fainting or dizziness |
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Heart Problems |
| ☐ | ☐ | Hepatitis Type _____ |
| ☐ | ☐ | Herpes |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | HIV Positive |
| ☐ | ☐ | Jaundice |
| ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Nervous Problems |
| ☐ | ☐ | Psychiatric Care |
| ☐ | ☐ | Radiation Treatment |
| ☐ | ☐ | Respiratory Disease |
| ☐ | ☐ | Scarlet Fever |
| ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | Skin Rash |
| ☐ | ☐ | Special Diet/Weight Loss |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Swollen Feet or Ankles |
| ☐ | ☐ | Swollen Neck Glands |
| ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Tonsillitis |
| ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Tumors or Growths |
| ☐ | ☐ | Ulcer |
| ☐ | ☐ | Venereal Disease |

**Have you ever taken any of these medications?**

| Yes | No | Medication |
|---|---|---|
| ☐ | ☐ | Blood |
| ☐ | ☐ | Coumadin |
| ☐ | ☐ | Warfarin |
| ☐ | ☐ | Diet Medication |
| ☐ | ☐ | Dexfenfluramine |
| ☐ | ☐ | Fen-phen |
| ☐ | ☐ | Pondimin |
| ☐ | ☐ | Redux |
| ☐ | ☐ | Levoxyl |
| ☐ | ☐ | Synthroid |

**Are you allergic to:**

| Yes | No | Allergy |
|---|---|---|
| ☐ | ☐ | Aspirin |
| ☐ | ☐ | Barbiturates |
| ☐ | ☐ | Codeine |
| ☐ | ☐ | Ibuprofen |
| ☐ | ☐ | Latex |
| ☐ | ☐ | Local Anesthesia |
| ☐ | ☐ | Metals |
| ☐ | ☐ | penicillin |

Other: ______________

**Have you ever had or been diagnosed with:**

| Yes | No | Condition |
|---|---|---|
| ☐ | ☐ | Artificial Joints, Screws, Pins, ect. |
| ☐ | ☐ | Bleeding abnormally, with extractions or surgery |
| ☐ | ☐ | Blood Disease |
| ☐ | ☐ | Congenital Heart Lesions |
| ☐ | ☐ | Heart Murmur |
| ☐ | ☐ | Hernia Repair |
| ☐ | ☐ | Mitral Valve Prolapse |
| ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Rheumatic Fever |

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ____________________________________________

· Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

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 clarification? ☐ 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