NAME: _____ SOCIAL SECURITY#_____

MAILING ADDRESS: _____ DATE OF BIRTH: _____

PHYSICAL ADDRESS: _____ CELL PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

OCCUPATION: _____ WORK PHONE: _____

GENERAL DENTIST: _____ PHYSICIAN: _____

IF MINOR, PARENT NAME: _____ PARENT SOCIAL SECURITY#_____

IF YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE DESCRIBE:

Y N Are you allergic to anesthetic, latex, penicillin, codeine, aspirin or any other medication? If yes, please list.

_____

Y N Are you taking any medication right now?
Please list all medications that you currently take on the back of this page.

Y N Do you have any bleeding problems and/or are you taking a blood thinner?

_____

Y N Does your physician, orthopedic surgeon or cardiologist require you to be pre-medicated with antibiotics prior to dental treatment?
If yes, what type of antibiotic do you use? _____

Y N Female patients: Are you pregnant?

Y N Have you in the past or are you now taking medication for osteoporosis?

_____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING ILLNESS: (CIRCLE ALL THAT APPLY):

Heart Trouble	*Joint Replacement*	*Kidney/Liver Problems*	*Diabetes*
High Blood Pressure	*Rheumatic Fever*	*Hepatitis*	*Cancer*
Prosthetic Heart Valve	*Shortness of Breath*	*Tuberculosis*	*Ulcers*
Heart Murmur	*Respiratory Problems*	*Thyroid Problems*	*Anemia*

PATIENT'S SIGNATURE: _____ **DATE**: _____

UPDATED: _____ DATE: _____

UPDATED: _____ DATE: _____