Last Name	First	Middle	Home#	Work#	Cell#
Date of Birth	SSN#	Driver's Licenses	Marital Status		Spouse's Name
Home Address	City	State	Zip		Referred By
Patient Occupation	Employer	Address	City/State	Zip	Years

Email_____ Preferred Method of Contact- Cell, Home, Text, E-Mail, Work—Please Circle

1. Are you in good health……..Y N
2. Are you now under a physician's care……Y N
3. Have you ever had any serious illnesses? If so Describe?_____
   _____
4. HOW DO YOU FEEL ABOUT SAVING YOUR TEETH?
   Not Important Very Important
   0 1 2 3 4 5 6 7 8 9 10

   HOW WOULD YOU EVALUATE YOUR SMILE?
   Ugly Beautiful
   0 1 2 3 4 5 6 7 8 9 10

DO YOU HAVE OR EVER HAD (please circle)

a. Rheumatic Fever or Rheumatic Heart Disease? Y N
b. Cardiovascular Disease (heart attack, heart trouble, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker?……Y N
c. Lung, Asthma, Emphysema, Tuberculosis, chest pains?……Y N
d. Seizures, Convulsions, Epilepsy, Fainting or dizziness?……Y N
e. Bleeding disorder, Anemia, Blood Transfusion? Do you bruise easily?……Y N
f. Liver Disease (jaundice, Hepatitis)?……..Y N
g. HIV Infection?……Y N
h. Diabetes?……Y N
i. Thyroid disease?……Y N
j. Arthritis?……Y N
k. Stomach Ulcers or Colitis?……Y N
l. Glaucoma?……Y N
m. Joint Replacement?……Y N
n. Radiation?……..Y N
o. Clicking or popping of the jaw?……Y N
p. Sinus or Nasal problems?……..Y N
q. Any disease, drug or transplant operation?…….Y N

5. ARE YOU USING ANY OF THE FOLLOWING?

a. Antibiotics……..Y N
b. Blood Thinners, Asprins..……..Y N
c. High Blood Pressure Meds……Y N
d. Tranquilizers…… Y N
e. Insulin or Oral anti-Diabetic Drugs?…… Y N
f. Digitalis, Inderal Nitroglycerin or other heart drugs?… Y N
g. Please list any medications taken, including prescriptions, herbal, vitamins, or minerals_____
   _____

9. ARE YOU ALLERGIC TO OR HAVE YOU AN ADVERSE REACTION TO:

a. Local Anesthesia?…… Y N
b. Penicillin or other antibiotics?…… Y N
c. Sedatives, Barbiturates?…… Y N
d. Asprin or Ibuprofen?…… Y N
e. Codeine or other pain killers?…….. Y N
f. Latex or Rubber products …… Y N
g. Other allergies or reactions? Please List_____
   _____
   _____

10. Do You Smoke or chew tobacco?…… Y N
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?…….. Y N
12. Have you had any serious problems associated with any previous dental treatment?…….. Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?……Y N

14. Snore/Sleep Apnea

a. Do you snore, gasp or choke while sleeping?……Y N

15. FOR WOMEN ONLY

Are you pregnant or is there any chance you might be pregnant?…… Y N
If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives.