❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.

First Name _____ Last Name _____

Birth Date _____ Soc. Sec. # _____

Home Address _____ Apt. # _____
Street

_____
City, Town State Zip

Home Phone _____ Cell Phone _____

Business Phone _____ Email _____

Referred By _____ General Dentist _____

Employer-Occupation _____

Bus. Address _____

Do you have, or have you had any of the following?

Heart Murmur	YES	NO	Hepatitis	YES	NO
Bacterial Endocarditis	YES	NO	Diabetes	YES	NO
Angina	YES	NO	Glaucoma	YES	NO
Arteriosclerosis	YES	NO	Asthma	YES	NO
High Blood Pressure	YES	NO	Urinary Infection	YES	NO
Low Blood Pressure	YES	NO	Kidney Disease	YES	NO
Anemia	YES	NO	Ulcers	YES	NO
Bleeding Problems	YES	NO	Cancer	YES	NO
Liver Disease	YES	NO	Radiation Therapy	YES	NO
Thyroid Disease	YES	NO	Chemotherapy	YES	NO
Lung Disease (T.B.)	YES	NO			

1. Are you in good health? YES NO
2. Are you presently under the care of a physician? YES NO
   If so, what for? _____
   _____
3. Are you presently taking any drug or medicine? YES NO
   If so, please list them _____
   _____
4. Are you taking Fosamax or any other bone replacement supplements? YES NO
5. Do you have heart trouble or cardiovascular disease? YES NO
6. Do you have mitral valve prolapse? YES NO
7. Do you have damaged or artificial heart valves? YES NO
8. Do you have an artificial hip or other prosthetic device? YES NO
9. Do you require antibiotic coverage for dental procedures? YES NO
10. Do you have a cardiac pacemaker? YES NO
11. Do you experience chest pain upon exertion? YES NO
12. Do you routinely take aspirin on a daily basis? YES NO

Pregnant? YES NO Nursing? YES NO Birth Control Pills? YES NO

PLEASE CIRCLE ANY OF THE FOLLOWING DRUGS TO WHICH YOU MAY BE ALLERGIC:

Penicillin
Erythromycin
Other Antibiotic _____
Aspirin
Ibuprofen (Motrin, Advil)
Codeine
Local Anesthetic
Adrenalin (Epinephrine)
Latex
Other Allergies? _____

Do you have any other medical problems not mentioned above? YES NO

If so, what is it? _____

Name and Address of Physician _____

_____

Signature _____ Date _____