WELCOME TO OUR PRACTICE !!

Please answer all the following questions so that we may better serve you.

Name _____
Last **First** **Middle** **How you wish to be addressed**

Address_____**City**_____**State**_____**Zip**_____
Date of Birth _____**SS#**_____**Home#**_____**Marital Status**_____
Additional Information: Cell Phone#_____Email Address_____
Employer_____Telephone#_____Present Position_____
Emergency Contact_____Relationship_____Phone#_____

SPOUSE INFORMATION

Spouse Name_____DOB_____SS#_____
Employer_____Present Position_____

How were you referred to our office?
___Established Patient: _____
___Phone Book ___Newspaper___Other (please explain) _____
Other family members in this practice_____

Medical History

Are you currently in the care of a physician? _____If yes, name of physician_____
Date of last doctor visit? _____ Purpose _____
What is your estimate of your general health? _____ Poor _____ Fair _____ Good

CIRCLE ANY OF THE FOLLOWING THAT YOU CURRENTLY HAVE OR EVER HAD:

Heart Problems	**Arthritis**	**Kidney Disease**	**Liver Disease**
Heart Murmur	**Diabetes**	**Jaundice**	**Thyroid Disease**
Artificial Valve	**Pacemaker**	**Digestive Disorders**	**Stomach Ulcers**
Mitral Valve Prolapse	**Glaucoma**	**High Cholesterol**	**Hormone Deficiency**
Tumor/Abnormal Growth	**Contact Lenses**	**Rheumatic Fever**	**Anemia/Blood Disorder**
Scarlet Fever	**Epilepsy/Seizures**	**Chemotherapy**	**Radiation Therapy**
Asthma	**Stroke**	**High Blood Pressure**	**Low Blood Pressure**
Emphysema	**Sinus Problems**	**Tuberculosis**	**Viral Infections**
Hepatitis	**Venereal Disease**	**HIV/AIDS**	**Emotional Problems**
Hepatitis Type_____	**Hives, Skin Rash**	**Hay Fever**	**Lumps, Swelling in Mouth**
Alcohol/Drug Dependency	**Prolonged bleeding due to a cut**		

Are you allergic to any medications? _____ Which ones? _____ Are you allergic to Latex? _____
Are you presently being treated for any illness? _____ Please explain _____
Do you have an artificial prosthesis (such as knee or hip replacement)?____ Do you require antibiotic before treatment? ___

List any medications you currently take: _____
_____

Please describe any current medical treatment, surgery, or other conditions that may possibly affect your dental treatment _____
Do you smoke? _____ How many packs per day? ____ Do you use smokeless tobacco?___ How often? ___
FEMALES: Are you pregnant? _____ MALES: Do you have any prostate disorders? _____
Patient's Signature _____ **Date** _____