Name _____ (Last / First / Middle) Address _____ (Number, Street)

City _____ State _____ Zip Code _____ Home Phone _____ Business Phone _____

Date of Birth _____ Sex ____ Age ____ S.S. # _____ Occupation _____

Employer _____ Employer's Address _____

Marital Status _____ Name of Spouse or Parents _____

Employer of Spouse _____

Name, address & S.S.# of person responsible for account _____

_____ Phone _____

Responsible party employed by and address _____

If you are completing this form for another person, what is your relationship to that person? _____

Name, address & phone of closest relative _____

Referred by _____

Have you or other members of your family been a patient in any of our office locations before? _____

If so, name _____

Dental Insurance Co. _____ Policy No. _____

Medical Insurance Co. _____ Policy No. _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. The name of my physician is _____

   The name of my dentist is _____
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes No
5. Have you had any serious illness or operation? ..... Yes No
6. Do you have or have you had any of the following diseases or problems?

a. Heart trouble	Yes	No	k. Kidney trouble	Yes	No
b. Heart murmur	Yes	No	l. Tuberculosis	Yes	No
c. Rheumatic fever	Yes	No	m. Emphysema	Yes	No
d. High or low blood pressure	Yes	No	n. Sexually transmitted diseases	Yes	No
e. Stroke	Yes	No	o. Epilepsy or seizures	Yes	No
f. Asthma	Yes	No	p. Psychiatric problems	Yes	No
g. Diabetes	Yes	No	q. Cancer	Yes	No
h. Hepatitis, jaundice or liver disease	Yes	No	r. AIDS	Yes	No
i. Arthritis	Yes	No	s. Thyroid condition	Yes	No
j. Stomach ulcers	Yes	No	t. Glaucoma	Yes	No

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ..... Yes No
8. Do you have any blood disorder such as anemia? ..... Yes No
9. Have you ever had radiation therapy for a tumor of the head or neck? ..... Yes No
10. Are you taking any drugs or medicine? ..... Yes No
11. Are you allergic to any drugs or medicine? ..... Yes No
12. Do you have any disease, condition, or problem not listed above that you think we should know about? ..... Yes No
13. Are you wearing contact lenses? ..... Yes No

Women

14. Are you pregnant? ..... Yes No
15. Are you nursing? ..... Yes No

I have read and understand the above. I will not hold the surgeon or his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____

_____
Signature of Patient

_____
Witness