PATIENT INFORMATION

Name: ______________________________ DOB: ____________________

Date of Last Dental Visit: ______________________________

Referred to Us By: ______________________________

DENTAL HEALTH HISTORY

YES	*NO*	
☐	☐	Are you apprehensive about dental treatment?
☐	☐	Are you dissatisfied with the appearance of your teeth?

MEDICAL HEALTH HISTORY

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

YES	*NO*	
☐	☐	Heart Problems
☐	☐	Bleeding Problems
☐	☐	Intestinal Problems
☐	☐	Bone or Joint Problems
☐	☐	Diabetes
☐	☐	Fainting Spells, Seizures, or Epilepsy
☐	☐	Stroke(s)
☐	☐	Thyroid Problems
☐	☐	Premedications Required by Physician
☐	☐	Cancer/Tumor
☐	☐	Tuberculosis or Other Respiratory Disease
☐	☐	Hepatitis, Jaundice, or Liver Trouble
☐	☐	HIV-Positive/AIDS
☐	☐	History of alcohol or drug abuse
☐	☐	Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If *Yes* to ANY of the above please describe:

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MEDICAL HEALTH HISTORY (FOR WOMEN ONLY)

YES	*NO*	
☐	☐	Are you pregnant?
		If so, expected delivery date:________________________
☐	☐	Are you nursing?

ALLERGIES

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MEDICATIONS

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SIGNATURE

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NAME *DATE*