Welcome to our office.....

Patient's Name ______________________________ Date of birth ______________

Name of parents (if child) ______________________________

Social Security # (Primary insured) ______________________________

Residence address ______________________________

City/State/Zip ______________________________ Phone # ______________

Business Address ______________________________

City/State/Zip ______________________________ Phone # ______________

Date of last physical exam ______________ Reason ______________

Physician's Name ______________________________ Phone # ______________

PLEASE ANSWER EACH QUESTION

Do you have or did you ever have any of the following ? **please circle**.

Diabetes	yes no	High Blood Pressure	yes no	Tuberculosis	yes no
Hepatitis	yes no	Bleeding Tendency	yes no	Radiation Treatment	yes no
Herpes	yes no	Heart or Chest Pain	yes no	Cortisone Treatment	yes no
Asthma	yes no	Frequent Swollen Ankles	yes no	Chemotherapy	yes no
Bronchitis	yes no	Rheumatic Fever	yes no	Convulsions	yes no
Anemia	yes no	Heart Murmur	yes no	HIV Positive, AIDS	yes no

Other ______________________________

Which of the following illnesses do you suffer from? **Please specify**.

Heart Problems ______________ Liver Problems ______________
Lung Problems ______________ Kidney Problems ______________

Are you **Allergic** to any of the following? **please circle**

Penicillin	yes no	Sulfa Drugs	yes no	Novocain	yes no	Codeine	yes no
Aspirin	yes no	Barbiturates(sleeping pills)	yes no	Other drugs (specify)	__________		

Please list all **medications** you are taking ______________________________
Are you pregnant? ______________________________
Are you under the care of a physician? Why? ______________________________
Have you ever responded unfavorably to medical or dental care? ______________________________
Have you been hospitalized within the last 5 years? Why? ______________________________
Do you get short of breath after little exertion? ______________________________
When was your last Dental checkup? ______________________________
Remarks: ______________________________

Signature ______________________________ Relationship______________

Reviewed by ______________ Date______________