

DATE:

PATIENT INFORMATION

Patient Name:			Email address:				Date:					
Address:	Last	First		М								
	Street	Talanhama, II.			pt. #		City	Callular/De	State			Zip
		Telephone: Hor								I П Sar	arat	ad
Height:	weight: _	Sex: LI M	ПГ	Спеск Арргор	riale Box.	L Willion	□ Single	Li Married	☐ Full Tim	e \square Par	t Tir	me
If Student,	Name of S	chool/College		City		State		Grade				
Patient's Emp	loyer:			Oc	cupation:				SS#:			_
Business Add	ress:	C.			uite#		Cit		Stat			Zip
Spouse Name		Street					City	Work P				Zip
		of emergency:										
		is form for another										
		us? Or how did y										
Name of Pers	on Respons	sible for this Acco	unt:					Relationship	to Patient:			
Address (if diff	ferent from ab	Street										
			11			Apt. #		City	State	Zip		
		Telephone:		The state of the s		ense #:	Work					
		7 0						1 1 1 1				
		erage Informati								,	1	
Name of Insu	red:				Kelations	nip to Patie	ent:		State:	7in:	_'_	
Address (if diff	ferent from al	bove):	D .	1 T : #.		City	/:	Data Emp	State,	_ z.ip		
SS #:	•		Drive	r's License #:	1.4.	T-11	Wle	Date Emp	Llama:			
Name of Emp	loyer:			_Union or Loca	al #:	l elephor	ie: Work:_	04-1-	Home:			
Address of Er	nployer: _				City:			State:		.ip:		
Dental Ins. Co	ompany: _				Group #:			Polic	:y/ID #:			_
		overage Informa										
Name of Insu	red:				Relations	hip to Patie	ent:		Birthdate:	/	_/_	
Address (if dif	ferent from at	bove):				City	y:		State:	Zip:		
SS #:			Drive	er's License #:_				Date Emp	loyed:			
Name of Emp	loyer:			_Union or Loc	al #:	Telephor	ne: Work:_		Home: _			
Dental Ins. Co	ompany: _				Group #:			Polic	:y/ID #:			
			AND DESCRIPTION OF THE PARTY OF	DENTA	L HIST	rory						
Please onews	r each au	estion by circling	Vesor	No								
		dental problem or o			be:)	es	No
		minations on a rou									es	No
		cavities or gum dis								100	es	No
		on a routine basis?									l'es	No
		d? Describe:								_	es	No
Do you like y											res	No
Do you like your smile? Why? Do you want to keep your remaining teeth?									les	No		
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind?									l'es	No		
Have your past experiences in a dental office been positive?								res	No			
		st:				of last full	mouth x-ra	y series:				
I CEPTIEV T	THAT THE	E ABOVE INFOR	MATIC	N IS COMPLE	TE AND	ACCURA	TE.					
		Signature:										
		(If p	atient is	a minor, include p	printed nam	ne and signa	ture of pare	nt or legal gua	ardian)			
				DO NOT WRI	TE IN T	HIS SPAC	E					

DENTIST'S COMMENTS:



2nd

3rd

HEALTH HISTORY

Last First M Please answer each question by checking the appropriate box or circling Yes or No. Are you in good health? Yes No 2. Date of last physical examination: Yes No 1/2	Patient Name:		Patient #: Da	te:						
A re you in good health?	Last	First M								
2. Date of last physical examination: 3. Are you now under the care of a physician? 4. Have you ever had any serious illness or operation or been hospitalized? 4. Have you ever had any serious illness or operation or been hospitalized? Please explain: 5. Are you taking any medication? 6. Are you taking any medication? 6. Are you taking any medication? 6. Are you taking any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you taking any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you taking any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you taking any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you taking any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you sensitive or allergic to any drugs or materials? 6. Please explain: 6. Are you serishive or allergic to any drugs or materials? 6. Please explain: 7. Please explain: 7. Please explain: 8. Are you serishive or allergic to any drugs or materials? 8. Are you serishive or allergic to any drugs or materials? 8. Are you serishive or allergic to any drugs or materials? 8. Are you serishive or allergic to any drugs or materials? 8. Are you serishive or allergic to any drugs or materials? 9. Do you have or have you had any of the following: Please check "Y" for Ye or "N" for No—answer all conditions: 9. Yes No 9. Do you have or have you had any of the following: Please check "Y" for Ye or "N" for No—answer all conditions: 9. Yes No 9. Do you have or have you had any of the following: Please check "Y" for Ye or "N" for No—answer all conditions: 9. Yes No 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Yes No 9. Do you have or have you had a change of which the following: Please check "Y" for Yes or "N" for Yes No No Replaced to Any No Repl										
If yes, what is the condition being treated? Doctor's name: 4. Have you ever had any serious illness or operation or been hospitalized? 5. Are you taking any medication? 6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 7. Yes No If yes, what? 6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 8. Are you sensitive or allergic to any drugs or materials? 8. Are you sensitive or allergic to any drugs or materials? 9. Do you have or have you had any of the following: Pease check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had change in you have you had change in you have problems associated with your menstrual period? 9. Do you ware a cardiac pacemaker, or have you had heart surgery? If yes, please explain: 10. Do you ware a cardiac pacemaker, or have you had heart surgery? If yes, please explain: 11. Have you seen a medical doctor? 12. Yes No Have you had a change in any medicati	1. Are you in good health?									
If yes, what is the condition being treated? Doctor's name: 4. Have you ever had any serious illness or operation or been hospitalized? 5. Are you taking any medication? 6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 7. Yes No If yes, what? 6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? 8. Are you sensitive or allergic to any drugs or materials? 8. Are you sensitive or allergic to any drugs or materials? 9. Do you have or have you had any of the following: Pease check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No—answer all conditions: 9. Do you have or have you had change in you have you had change in you have problems associated with your menstrual period? 9. Do you ware a cardiac pacemaker, or have you had heart surgery? If yes, please explain: 10. Do you ware a cardiac pacemaker, or have you had heart surgery? If yes, please explain: 11. Have you seen a medical doctor? 12. Yes No Have you had a change in any medicati	Date of last physical examination	Date of last physical examination:								
Please explain: Are you using any redication? Yes No If yes, what? What dosage? Yes No If yes, what? Yes No If yes Yes No If yes Yes Yes No If yes Yes Yes Yes No If yes Yes	3. Are you now under the care of a physician?									
Please explain: Are you using any redication? Yes No If yes, what? What dosage? Yes No If yes, what? Yes No If yes Yes No If yes Yes Yes No If yes Yes Yes Yes No If yes Yes	If yes, what is the condition being treated?									
Please explain: Are you using any redication? Yes No If yes, what? What dosage? Yes No If yes, what? Yes No If yes Yes No If yes Yes Yes No If yes Yes Yes Yes No If yes Yes	Doctor's name: Telephone #:									
If yes, what?	4. Have you ever had any serious illness or operation or been hospitalized?									
If yes, what?	Please explain:									
If yes, what? New you ever been premedicated with antibiotics for your dental treatment? Yes No	5. Are you taking any medication?									
If yes, what? New you ever been premedicated with antibiotics for your dental treatment? Yes No	If yes, what? What dosage?									
8. Are you sensitive or allergic to any drugs or materials?										
Aspirin										
D D Allogies or Hives D D Contisoner Medicine D D N Hemophilia D D D D D D D D D										
D D Allogies or Hives D D Contisoner Medicine D D N Hemophilia D D D D D D D D D	☐ Aspirin ☐ Codeine ☐ La	atex Other If Other, please	list:	********	Yes	No				
Y N Allergies or Hives Y N Diabetes Y N Difficulty in Swallowing Y N Herpes Y N Remunities Fever Y N Allergies to Metals Y N Difficulty in Swallowing Y N Herpes Y N Remunities Y N Anemia Y N Dirty Addiction Y N High Blood Pressure Y N Sinus Trouble Y N Angina Pectors Y N Angina Pectors Y N Stroke Y N Angina Petotros Y N Angina Petotros Y N Expensive Bleeding Y N Kiffice Policeses Y N Stroke Y N Anthritis Y N Expensive Bleeding Y N Kiffice Policeses Y N Stroke Y N Anthritis Y N Faminia Spells or Seizures Y N Liver Disease Y N Tomach Ulsers Y N Anthritis Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Stroke Y N Blood Transfusion Y N Hay Fever Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Mental Disorder Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Tomach Ulsers Y N Faminia Spells or Seizures Y N Faminia Spell	Do you have or have you had a									
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Y N Blood Disease	□Y □N Arthritis	□ Y □ N Epilepsy or Seizures	□Y □N Joint Replacement	□ Y □ N Stomach						
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10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: 10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: 10. Do you smoke, chew, use snuff or any other forms of tobacco? Cigarettes Cigars Chew Snuff Other Yes No 11. Do you consume alcoholic beverages? If yes, how much? Yes No 12. Do you consume alcoholic beverages? If yes, how much? Yes No 13. Have you ever taken the drug "Fen-Phen" or "Redux"? or Bisphosphonates? Yes No 14. Are you pregnant? If yes, how many months? N/A Yes No 15. Do you have any problems associated with your menstrual period? N/A Yes No 15. Do you have any problems associated with your menstrual period? N/A Yes No 16. Do you take birth control pills? N/A Yes No 17. Is there anything we should know about your health that is not mentioned above? Yes No 18. It CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. Date: Signature: Signature: Signature Signature Yes No 19. Have you seen a medical doctor? Yes No 19. Have you had a change in any medication? Yes No 19. Have you had a change in any medication? Yes No 19. Have you had a change in any medication? Yes No 19. Have you had a change in any medication? Yes No 19. Have you had a change in any medical condition Signature: Date: Signature: Signature: Date: Signature: Signature: Date: Signature: Signature: Signature: Date: Signature: Signature: Date: Signature: Signa	☐ Y ☐ N Chemotherapy	☐ Y ☐ N Heart Ailments or Attack	☐ Y ☐ N Pain in Jaw Joints	□ Y □ N Tumors o						
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13. Have you ever taken the drug "Fen-Phen" or "Redux"? or Bisphosphonates?	12 Do you consume alcoholic heve	erages? If yes how much?			Ves	No				
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15. Do you have any problems associated with your menstrual period?	14 Are you pregnant? If yes, how I	many months?	Sprioriates		Yes					
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