Today's Date_____

Health History

Patient's Name _____Home Phone_____ Cell _____
Name you prefer to be called_____**Email Address** _____
Home Address _____ City_____ Zip _____
Occupation _____ Employed by _____ How Long _____
Business Address _____ Work Phone _____
Physician's Name _____ Last Physical _____
Date of Birth_____Hgt_____Wt_____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed
SS No. _____**Referred by** _____
Spouse or Parent (if minor) _____

Responsible Party/Insurance

Person responsible for account _____Phone _____
SS No. _____Date of Birth _____
Occupation _____ Employed by _____ How Long _____
Business Address _____Phone _____
Dental Insurance Carrier _____Phone _____
Address _____
Subscriber No. _____ Group No. _____Group Plan _____

Dental History

1. When did you have your last dental exam? _____Dentist's Name _____
2. Was restorative treatment recommended? Yes No Completed? Yes No
3. How often do you brush your teeth? _____ Do you floss? Yes No
4. Do you wear removable appliances? Yes No

General Health Questionnaire

1. Are you being treated by a physician at this time? Yes No For What? _____
   Any drug allergies? Yes No List _____
   Do you have or have you ever had any of the following? (circle all that apply)

Heart Disease	Kidney TroubleTuberculosis	
Heart Murmur	Diabetes	Radiation Treatment
Mitral Valve Prolapse	Asthma	Chemotherapy
Pacemaker	Epilepsy	Venereal Disease
Rheumatic Fever	History of Cancer	Sinusitis
Prosthetic Joints	Psychiatric Treatment	Glaucoma
High Blood Pressure	Anemia	Arthritis
Low Blood Pressure	GI Ulcers	AIDS
Bleeding Problems	Severe Pain	Other
Hepatitis	Are you pregnant?_____	
Liver Trouble	Have you reached menopause_____	

List current medications:_____