PATIENT NAME					TODAY'S DATE				
HOME ADDRESS				-	DATE OF BIRTH				
				_					
1	EMAIL CELL PHONE								
EMPLOYER Consent to receive								S NO	
INSURANCE CO.				-	BUSINESS PHONE			_	
					STORY				
PHYSICIAN OF	FICE PHO YES	DNE . NO			DATE OF LA	ST EXAM			
1. Are you under medical treatment now?			6. Are	you	ı allergic to or have had	I any reactions to	the fol	llowing?	
2. Have you ever been hospitalized for any				NO	l and amouthation	YES NO			
surgical operation or serious illness?					Local anesthetics (eg. novocaine)	□ □ Sedativ	es		
3. Are you taking any medication(s)					Penicillin or other	□ □ Aspirin			
9 1 1			_		anibiotics				
If yes, what medication(s) are you taking?		_			Sulfa Drugs	□ □ Latex			
		_			Other				
4. Do you use tobacco?			7. Are	you	required to be pre-me	dicated before		YES NO	
5. Do you use alcohol, cocaine or other drugs? dental treatment? 8. WOMEN ONLY: YES									
					you pregnant or think	vou mav be pred			
			b) Are	you nursing?				
			C) Are	you taking birth contro	ol pills?			
11. Do you have any of the following?		,	VEO. NO.			COMMENTS			
YES NO High Blood Pressure Kidney E	iseases		YES NO	oint	Replacement or Implant				
☐ ☐ Heart Attack ☐ ☐ AIDS or	HIV Infec			lepa	titis / Jaundice ach Troubles / Ulcers				
☐ ☐ Rheumatic Fever ☐ ☐ Thyroid I☐ ☐ Swollen Ankles ☐ ☐ Heart Co				Strok	Э				
☐ ☐ Fainting / Seizures ☐ ☐ Cardiac ☐ ☐ Asthma ☐ ☐ Frequent		er		∃ay F Radia	ever / Allergies tion Therapy				
□ □ Low Blood Pressure □ □ Anemia □					☐ Recent Weight Loss ☐ Do you experience any trouble				
☐ ☐ Epilepsy / Convulsions ☐ ☐ Emphysema ☐ ☐ Leukemia ☐ ☐ Cancer					Disease ratory Problems	with sleeping, sr	_		
□ □ Diabetes □ □ Athritis						sleep apnea?	YES	S NO	
			<u> </u>						
ŀ			ENIAL	. HI	STORY				
1. Do your gums bleed while brushing or flossing	YES]? □	NO		3. Г	o you have frequent hea	adaches?	YES	NO	
2. Are your teeth sensitive to hot or cold liquids/ foods?					o you clench or grind yo				
3. Are your teeth sensitive to sweet or sour liquid	□ ds/			10. C	o you bite your lips or cl	neeks frequently?			
foods? 4. Do you feel pain to any of your teeth?					lave you ever had any din the past?	ifficult extractions			
5. Do you have any sore or lumps in or near you	r \square				lave you had any orthod	ontic treatment?			
mouth? 6. Have you had any head, neck or jaw injuries?					lave you ever had prolor				
7. Have you ever experienced any of the following					ollowing extraction?	- # · · · · · · · · · · · · · · ·			
problems in your jaw? a) Clicking					lave you ever had instru orrect method of brushin				
b) Pain (joint, ear, side of face?)				15. H	lave you ever had instru		_	_	
c) Difficulty in opening or closing?d) Difficulty in chewing?				С	are of your gums?				
I certify that I have	read and und	erstand			on. To the best of my knowledge, the al	pove questions have bee acc	urately ans	swered.	
	providing incor	rect info	ormation can l	e dang	rerous to my health.				
SIGNATURE X									