



# Welcome ...

Date \_\_\_\_\_

Correct answers to the following questions will allow our office to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address, City, St., Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Employed by \_\_\_\_\_ Emp. Phone Number \_\_\_\_\_

Dental Ins. Co. Name \_\_\_\_\_ Policy I.D. # \_\_\_\_\_

Address, City, St., Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Referred By \_\_\_\_\_ Phone \_\_\_\_\_

Why are you seeking dental treatment ? \_\_\_\_\_

Please have receptionist copy your insurance card for our files.

**Please answer each question. Check YES or NO. If in doubt, leave blank.**

1. Are you in good health now ? .....
2. Are you now under the care of a physician ? .....  
If so, what is the condition being treated ? \_\_\_\_\_
3. Have you ever been hospitalized or had a serious illness ? .....  
If yes, explain \_\_\_\_\_
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal than previously ?
5. ( Woman ) Are you pregnant ? If so, give due date \_\_\_\_\_
6. Do you use tobacco in any form ? If yes, how much \_\_\_\_\_
7. Do you use alcoholic beverages ? ( More than two drinks per day ) .....
8. Do you have or have you ever had any of the following ? .....

GENERAL	Yes	No	HEART / BLOOD VESSELS	Yes	No
Tire easily, weakness .....	_____	_____	Rheumatic fever .....	_____	_____
Marked weight change .....	_____	_____	Heart murmur .....	_____	_____
Night sweats .....	_____	_____	Chest pain / discomfort .....	_____	_____
Persistent fever .....	_____	_____	Heart attack / trouble .....	_____	_____
<b>SKIN</b>			Shortness of breath .....	_____	_____
Eruptions ( rash ) hives .....	_____	_____	Swelling of ankles .....	_____	_____
Change in skin color .....	_____	_____	High blood pressure .....	_____	_____
<b>EYES</b>			Congenital heart disease .....	_____	_____
Visual change .....	_____	_____	Artificial heart valve .....	_____	_____
Glaucoma .....	_____	_____	Pacemaker .....	_____	_____
<b>EARS</b>			Heart surgery .....	_____	_____
Loss of hearing .....	_____	_____	Other .....	_____	_____
Ringling in ears .....	_____	_____	<b>BONE / MUSCLES</b>		
<b>NOSE</b>			Arthritis / rheumatism .....	_____	_____
Frequent nosebleeds .....	_____	_____	Artificial joints .....	_____	_____
Sinus problems .....	_____	_____	<b>DIGESTIVE SYSTEM</b>		
<b>THROAT</b>			Hepatitis .....	_____	_____
Soreness / hoarseness .....	_____	_____	Jaundice .....	_____	_____
<b>NERVOUS SYSTEM</b>			Ulcers .....	_____	_____
Stroke .....	_____	_____	Change in appetite .....	_____	_____
Headaches .....	_____	_____	Black, bloody or pale stools .....	_____	_____
Convulsions / epilepsy .....	_____	_____	<b>URINARY</b>		
Numbness / tingling .....	_____	_____	Kidney disease .....	_____	_____
Dizziness / fainting .....	_____	_____	Increase in frequency of urination ( night ) .....	_____	_____
Psychiatric treatment .....	_____	_____	Burning on urination .....	_____	_____
<b>RESPIRATORY</b>			Urethral discharge .....	_____	_____
Tuberculosis .....	_____	_____	Bloody urine .....	_____	_____
Emphysema .....	_____	_____	Veneral disease .....	_____	_____
Asthma / hay fever .....	_____	_____			
Persistent cough .....	_____	_____			
Sputum production ( phlegm ) .....	_____	_____			

( over )

