Full Name ______________________________
Street Address ______________________________
City ____________________ State ____ Zip __________
Employer ____________________ How long? __________
Spouse Name ______________________________
Spouse Employer ____________________ Phone __________
Dependent Children Names/Birthdays ____________________
Other Family Seen Here ______________________________
Last Dental Visit __________ Dentist's Name ____________________

Preferred Name ______________
Birthday ______________
Home Phone ______________
Work Phone ______________
Soc. Sec. # ______________
Marital Status ______________
Referred by: (please circle)
Family Friend Co-worker Other
Name ______________

Please circle any of the following which you feel need attention, or would like to discuss:
Toothache Cavities Bleeding/Infected Gums Bad Breath/Taste Broken Teeth Chewing Pain Missing Teeth Hot/Cold Sensitivity Appearance Failed Fillings Dentures/Partials Implants Bonding Crowns Full Mouth Rehabilitation
How apprehensive are you about dental care (circle) NOT AT ALL A LITTLE VERY TERRIFIED

Please circle if you have, or have had, any of the following:

AIDS	Excessive Bleeding	Liver Disease	Tuberculosis
Allergies to:	Fainting	Lung Problems	Tumors
______________	Glaucoma	Mental Disorders	Ulcers
______________	Growths	Pacemaker	Venereal Disease
Arthritis	Hay Fever	Pregnant at present time	
Artificial Joints	Head Injuries	Radiation Treatment	Codeine Allergy
Asthma	Heart Disease	Respiratory Problems	Penicillin Allergy
Blood Disease	Heart Murmur	Rheumatic Fever	Other
Cancer	Hepatitis	Rheumatism	______________
Diabetes	High Blood Pressure	Sinus Problems	______________
Dizziness	Jaundice	Stomach Problems	______________
Epilepsy	Kidney Disease	Stroke	______________
			______________

Please list any medications you are currently taking, and what they are for in general terms:

Have you ever had any complications during or following dental treatment? NO YES (please explain below)
____
____
Are you now under the regular care of a physician? NO YES Physician's name ____________________
Do you have any health problems that need further clarification? NO YES (please explain below)
____
____
To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any changes in my health or medications, I will the inform the dentist or his assistants at the next appointment without fail.

______________________________ ____________________
Signature of patient, parent, or guardian Date