

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History Name _____

Physician _____ Office Phone _____ Date of Last Exam _____

- | | |
|--|---|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Are you allergic to or have you had any reactions to the following?
 Local Anesthetics (e.g. Novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No
 Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No
 Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No
 Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No
 Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No
 Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No
 Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No
 Any Metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No
 Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No
 Other (please list) _____</p> <p>10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Women Only:
 a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
 b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No
 c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

7. Do you have or have you had any of the following?

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|----|--------------|--------------------------|-----|--------------------------|----|-----------------|--------------------------|-----|--------------------------|----|----------------|--------------------------|-----|--------------------------|----|---------------------|--------------------------|-----|--------------------------|----|--------|--------------------------|-----|--------------------------|----|--------------------|--------------------------|-----|--------------------------|----|------------------------|--------------------------|-----|--------------------------|----|----------|--------------------------|-----|--------------------------|----|----------|--------------------------|-----|--------------------------|----|-----------------|--------------------------|-----|--------------------------|----|-----------------------|--------------------------|-----|--------------------------|----|-----------------|--------------------------|-----|--------------------------|----|--|---------------|--------------------------|-----|--------------------------|----|-------------------|--------------------------|-----|--------------------------|----|--------------|--------------------------|-----|--------------------------|----|--------|--------------------------|-----|--------------------------|----|------------------|--------------------------|-----|--------------------------|----|--------|--------------------------|-----|--------------------------|----|-----------|--------------------------|-----|--------------------------|----|--------|--------------------------|-----|--------------------------|----|-----------|--------------------------|-----|--------------------------|----|------------------------------|--------------------------|-----|--------------------------|----|----------------------|--------------------------|-----|--------------------------|----|------------------------------|--------------------------|-----|--------------------------|----|---------------------------|--------------------------|-----|--------------------------|----|---|-------------|--------------------------|-----|--------------------------|----|---------------|--------------------------|-----|--------------------------|----|--------|--------------------------|-----|--------------------------|----|-----------------------|--------------------------|-----|--------------------------|----|--------------|--------------------------|-----|--------------------------|----|-------------------|--------------------------|-----|--------------------------|----|----------|--------------------------|-----|--------------------------|----|--------------------|--------------------------|-----|--------------------------|----|---------------|--------------------------|-----|--------------------------|----|---------------|--------------------------|-----|--------------------------|----|----------------------|--------------------------|-----|--------------------------|----|-----------------------|--------------------------|-----|--------------------------|----|-------|--------------------------|-----|--------------------------|----|
| <table border="0"> <tr><td>High Blood Pressure</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Heart Attack</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Rheumatic Fever</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Swollen Ankles</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Fainting / Seizures</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Asthma</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Low Blood Pressure</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Epilepsy / Convulsions</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Leukemia</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Diabetes</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Kidney Diseases</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>AIDS or HIV Infection</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Thyroid Problem</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table> | High Blood Pressure | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Heart Attack | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Rheumatic Fever | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Swollen Ankles | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Fainting / Seizures | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Asthma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Low Blood Pressure | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Epilepsy / Convulsions | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Leukemia | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Diabetes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Kidney Diseases | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | AIDS or HIV Infection | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Thyroid Problem | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <table border="0"> <tr><td>Heart Disease</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Cardiac Pacemaker</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Heart Murmur</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Angina</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Frequently Tired</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Anemia</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Emphysema</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Cancer</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Arthritis</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Joint Replacement or Implant</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Hepatitis / Jaundice</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Sexually Transmitted Disease</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Stomach Troubles / Ulcers</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table> | Heart Disease | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Cardiac Pacemaker | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Heart Murmur | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Angina | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Frequently Tired | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Anemia | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Emphysema | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Cancer | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Arthritis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Joint Replacement or Implant | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Hepatitis / Jaundice | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Sexually Transmitted Disease | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Stomach Troubles / Ulcers | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <table border="0"> <tr><td>Chest Pains</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Easily Winded</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Stroke</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Hay Fever / Allergies</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Tuberculosis</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Radiation Therapy</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Glaucoma</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Recent Weight Loss</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Liver Disease</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Heart Trouble</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Respiratory Problems</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Mitral Valve Prolapse</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Other</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table> | Chest Pains | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Easily Winded | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Stroke | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Hay Fever / Allergies | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Tuberculosis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Radiation Therapy | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Glaucoma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Recent Weight Loss | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Liver Disease | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Heart Trouble | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Respiratory Problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Mitral Valve Prolapse | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Other | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| High Blood Pressure | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Attack | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rheumatic Fever | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Swollen Ankles | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fainting / Seizures | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Asthma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Low Blood Pressure | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Epilepsy / Convulsions | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Leukemia | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kidney Diseases | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AIDS or HIV Infection | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Thyroid Problem | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Disease | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cardiac Pacemaker | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Murmur | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Angina | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Frequently Tired | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anemia | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Emphysema | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cancer | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Arthritis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Joint Replacement or Implant | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hepatitis / Jaundice | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sexually Transmitted Disease | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stomach Troubles / Ulcers | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chest Pains | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Easily Winded | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stroke | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hay Fever / Allergies | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tuberculosis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Radiation Therapy | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Glaucoma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recent Weight Loss | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Liver Disease | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Trouble | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Respiratory Problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mitral Valve Prolapse | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Additional Medications or Information:

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I acknowledge receipt of notice of privacy practices.

X _____
 Signature of patient (or parent/guardian if minor) Date