PERSONAL HISTORY

It is a pleasure to welcome you to our office.
The following information will help us in preparing your clinical records.
Of course all information will be kept in strict confidence.

PLEASE PRINT

Date _____

_____
Last Name *First Name* *Middle Name*

___ Male ___ Female
___ Widow ___ Single
___ Widower ___ Married
___ Separated ___ Divorced

Driver's License # _____ Social Security # _____

Date of Birth _____ Home Phone _____ Mobile Phone _____

Home Address _____
Number Street Apt./Unit

_____
City State Zip Code

Employer _____ Business Telephone _____

Business Address _____
Number Street City State Zip Code

Occupation _____ How long at present position _____

Emergency Contact _____

Home Phone _____ Business Phone _____

Who came with you to this office today? _____

Relation to patient _____

Who referred you to our office? _____

INSURANCE INFORMATION

Medical Insurance Carrier	Group Number	I.D. Number	Subscriber	Relationship

Dental Insurance Carrier	Group Number	I.D. Number	Subscriber	Relationship

Parent/Guardian or person responsible _____
Print Name Signature

_____
Street City State Zip Code Phone Number

Employer _____ Occupation _____

Business Address _____ Social Security # _____

Driver's License # _____

MEDICAL HISTORY

Age _____

Dentist _____ Physician _____ Orthodontist _____

Dentist Phone _____ Physician Phone _____ Orthodontist Phone _____

Are you under a Physician's care at the present time? Yes___ No ___ If yes, for what condition? _____

Height _____ Weight _____

Do you smoke? _____ How much? _____

Do you drink Alcohol? _____ How much? _____

Do you have a history of or current problems with:

A recent weight change	Yes	No	_____	Heart disease	Yes	No	_____
Excessive thirst	Yes	No	_____	Angina or chest pain	Yes	No	_____
Diabetes	Yes	No	_____	Liver disease	Yes	No	_____
Cuts which have not healed	Yes	No	_____	Hepatitis	Yes	No	_____
Stroke	Yes	No	_____	Anemia	Yes	No	_____
Dizzy Spells	Yes	No	_____	Do you have a bleeding tendency?	Yes	No	_____
Shortness of breath	Yes	No	_____	Excessive bleeding	Yes	No	_____
Lung Disease	Yes	No	_____	High blood pressure	Yes	No	_____
Asthma	Yes	No	_____	Thyroid disease	Yes	No	_____
Bronchitis	Yes	No	_____	Tuberculosis	Yes	No	_____
Frequent cough	Yes	No	_____	Stomach pain	Yes	No	_____
Drug abuse	Yes	No	_____	Kidney disease or infection	Yes	No	_____
Immune Suppression Disorder	Yes	No	_____	Glaucoma	Yes	No	_____
Hay Fever	Yes	No	_____	Contact lenses	Yes	No	_____
Sinus problems	Yes	No	_____	Seizures	Yes	No	_____
Rheumatic Fever or Heart Murmur	Yes	No	_____	Are you now pregnant?	Yes	No	_____
Scarlet Fever	Yes	No	_____	Have you donated blood lately?	Yes	No	_____
Latex allergy	Yes	No	_____	Chemotherapy ***or*** Radiation therapy?	Yes	No	_____
Have you taken Zometa or Aredia	Yes	No	_____	Are you able to climb a flight of stairs?	Yes	No	_____

Have you ever taken anything for osteoporosis like Fosamax or Boniva? Yes ____ No ____

How often do you take aspirin? _____

Have you ever had anesthesia before? _____

What other serious illnesses or injuries have you had? _____ None

_____

_____

_____

What operations or surgeries have you had? _____ None

_____

_____

_____

What medications, pills, and herbal / nutritional supplements are you taking now? _____ None

_____

_____

What medication(s) are you allergic to? _____ None

_____

_____

What is your main problem?

_____ Pain _____ Swelling _____ Other

Duration: _____ Days _____ Weeks _____ Months

Remarks: _____

_____

_____

_____ _____

Patients's Signature and / or Legal Guardian Date