Date__________

Name ______________________ Social security # __________ Age ____ Birthdate ______

Medical Doctor____________________________ Date of last medical exam__________

Doctor's Address____

Doctors Phone (____)____________________________

Do you have or have you had any of the following? Please 'X'

____Heart Problems
____High B/P
____Low B/P
____Mitral Valve Prolapse
____Diabetes
____Ulcer
____Tuberculosis
____Pacemaker
____Radiation Treatment
____Immune System disorders (including AIDS, HIV, ARC)

____Hepatitis
____Anemia
____Arthritis
____Epilepsy
____Stroke
____Heartattack
____Heart Murmur
____Venereal Disease
____Glaucoma

____Asthma
____Cancer
____Psychiatric care
____Rheumatic Fever
____Scarlet Fever
____Sinus Problems
____Excessive Bleeding
____Jaundice
____Artificial Joints
____Other

____
(List "other" issues)

Does your medical doctor require you to pre-medicate with antibiotics before a procedure? _______

List any Allergies to foods or drugs or latex____

Are you Pregnant__________? Are you currently taking oral contraceptives________?

Are you currently taking any medications? Yes_____ No _____

Please list the medications you are taking____

____

DENTAL HISTORY

Are you having any discomfort at this time? ____

How long since your last dental visit? ____

Do you have or have you ever had any of the following? Please 'X'

____Loose teeth
____Sensitive to Hot
____Sensitive to cold
____Sensitive to sweets
____Sensitive to Biting

____Clenching/Grinding
____Change in Bite
____Bleeding, sore gums
____Clicking/popping jaw
____Lumps in mouth

___Root canal
___Burning tongue/lips
___Trauma to jaws or teeth
___Unhappy Dental Experiences

Do you have any objection to our taking cavity-detecting x-rays whenever diagnosed necessary?
___ Yes ___No