### WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.

The better we communicate, the better we can care for you.

ABOU	JT YOU
Name	
Preferred Name	□ Male □ Female
☐ Single ☐ Married ☐ Divorced	☐ Widowed ☐ Separated
Birthdate/ Age	_ SS #
Address	
City	State Zip
Email	
Home # V	Vork #
Mobile #	Fax #
Whom may we thank for referring	you?
Other family members seen by us _	
Last visit date	
Employer	Employer Ph #
Employer Address	
How long employed there?	
SPOUSE	
Name	
Home # V	
Mobile # E	Birthdate//
Email	

2 ACCO	UNT INFO
PERSON RESPONSIE	
Home # Mobile #	Work #
Billing Address City SS#	State Zip

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you have a question at any time, please ask us. We are happy to help.

<b>/ ^ \</b>		
(3)	INSURAN	CE
D 11 M		
Provider Name		
Provider Address _		
City	State	Zip
Phone #		
Group #		

Insured's Ph#

\*ID# is sometimes different that SS#

IF YOU HAVE A SECONDARY INSURANCE PLEASE LET A TEAM MEMBER KNOW.

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4		RI
_		

Insured's Name \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ Insured's Employer\_\_\_\_\_

Relation \_\_\_

Insured's SS#

#### EMINDER INFO

Because we know your life is busy, we use an Electronic Appointment Reminder and Messaging System. Please check all that you prefer, as our best way to contact you.

- ☐ Email Only ☐ Text Message Only ☐ Text Message & Email ☐ Personal Phone Call ☐ Don't Need A Reminder ☐ Home ☐ Work ☐ Cell

## CONTACT INFO

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name	Relation
Home #	Work #

(6)	MEDICAL	HISTORY

Anesthetics  Please list any other drugs/materials that you are allergic to:  HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?  Abnormal Bleeding Yes No Herpes/Fever Blisters Yes No Alcohol / Drug Abuse Yes No High Blood Pressure Yes No High Blood Pressure Yes No High Blood Pressure Yes No Hospitalized For any reason Yes No Kidney Problems Yes No Kidney Problems Yes No Liver Disease Yes No Low Blood Pressure Yes No Congenital Heart Defect Yes No Pacemaker Yes No Pacemaker Yes No Pifficulty Breathing Yes No Radiation Treatment Yes No Emphysema Yes No Radiation Treatment Yes No Rheumatic/ Yes No Rheumatic/ Yes No Scarlet Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Scarlet Fever Yes No Scizures Yes No Scizule Cell Disease Yes No Sickle	n 1 1	1		
Are you currently under the care of a physician?				
Are you currently under the care of a physician?				
Please explain  Your current physical condition	Phone #	Las	t visit date	
Your current physical condition Good Fair Poor Do you smoke or use tobacco in any form? Yes No Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes No Please list each one:  Have you ever taken Phen-Fen? Yes No (Also known as Redux or Pondimin) If yes, when?  Are you taking any medications for Osteoporosis? Nes No If so, what?  ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?  Aspirin Yes No Dental Yes No Dental Yes No Latex Yes No Dental Yes No Anesthetics  Please list any other drugs/materials that you are allergic to:  HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?  Abnormal Bleeding Yes No Herpes/Fever Blisters Yes No Anemia Yes No High Blood Pressure Yes No High Blood Pressure Yes No High Blood Pressure Yes No Anemia Yes No Liver Disease High Blood Pressure Yes No Liver Disease Yes No Liver Disease Yes No Cancer/Chemotherapy Yes No Low Blood Pressure Yes No Cancer/Chemotherapy Yes No Low Blood Pressure Yes No Cancer/Chemotherapy Yes No Cancer/Chemotherapy Yes No Cangenital Heart Defect Yes No Difficulty Breathing Yes No Psychiatric Problems Yes No Difficulty Breathing Yes No Scarlet Fever Yes No Frequent Headaches Yes No Sickle Cell Disease Yes No Anter Yes No Yes No Sickle Cell Disease Yes No Sickle Cell Disease Yes No Sickle Cell Disease	Are you currently under	r the care c	f a physician? 📮 Yes 📮	l No
Your current physical condition Good Fair Poor Do you smoke or use tobacco in any form? Yes No Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes No Please list each one:  Have you ever taken Phen-Fen? Yes No (Also known as Redux or Pondimin) If yes, when?  Are you taking any medications for Osteoporosis? Nes No If so, what?  ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?  Aspirin Yes No Dental Yes No Dental Yes No Latex Yes No Dental Yes No Anesthetics  Please list any other drugs/materials that you are allergic to:  HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?  Abnormal Bleeding Yes No Herpes/Fever Blisters Yes No Anemia Yes No High Blood Pressure Yes No High Blood Pressure Yes No High Blood Pressure Yes No Anemia Yes No Liver Disease High Blood Pressure Yes No Liver Disease Yes No Liver Disease Yes No Cancer/Chemotherapy Yes No Low Blood Pressure Yes No Cancer/Chemotherapy Yes No Low Blood Pressure Yes No Cancer/Chemotherapy Yes No Cancer/Chemotherapy Yes No Cangenital Heart Defect Yes No Difficulty Breathing Yes No Psychiatric Problems Yes No Difficulty Breathing Yes No Scarlet Fever Yes No Frequent Headaches Yes No Sickle Cell Disease Yes No Anter Yes No Yes No Sickle Cell Disease Yes No Sickle Cell Disease Yes No Sickle Cell Disease	Please explain			
Do you smoke or use tobacco in any form?	теазе ехрипт			
Are you taking any prescription / over-the-counter or herbal supplement drugs?	Your current physical co	ondition [	□ Good □ Fair □ Poor	
Have you ever taken Phen-Fen? Yes No (Also known as Redux or Pondimin) If yes, when?  Are you taking any medications for Osteoporosis? Yes No If so, what?  ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?  Aspirin Yes No Erythromycin Yes No Penicillin Yes No Codeine Yes No Jewelry/Metals Yes No Other Yes No Dental Yes No Latex Yes No Other Yes No Anesthetics  Please list any other drugs/materials that you are allergic to:  HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?  Abnormal Bleeding Yes No Herpes/Fever Blisters Yes No Alcohol / Drug Abuse Yes No High Blood Pressure Yes No Arthritis Yes No Hospitalized Arthritis Yes No Hospitalized Arthritis Yes No Hospitalized For any reason Yes No Asthma Yes No Low Blood Pressure Yes No Asthma Yes No Low Blood Pressure Yes No Asthma Yes No Low Blood Pressure Yes No Concer/Chemotherapy Yes No Low Blood Pressure Yes No Congenital Heart Defect Yes No Pacemaker Yes No Congenital Heart Defect Yes No Radiation Treatment Yes No Difficulty Breathing Yes No Radiation Treatment Yes No Emphysema Yes No Scarlet Fever Yes No Frequent Headaches Yes No Sickle Cell Disease	Do you smoke or use to	bacco in ar	ny form? 🖵 Yes 🖵 No	
Have you ever taken Phen-Fen?  Yes No (Also known as Redux or Pondimin) If yes, when?  Are you taking any medications for Osteoporosis?  Yes No If so, what?  ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?  Aspirin Yes No Erythromycin Yes No Penicillin Yes No Dental Yes No Latex Yes No Other Yes No Dental Yes No Latex Yes No Other Yes No Penicillin Yes No Dental Yes No Latex Yes No Other Yes No Dental Yes No Herpes/Fever Blisters Yes No High Blood Pressure Yes No High Blood Pressure Yes No Hospitalized For any reason Yes No Hospitalized For any reason Yes No Kidney Problems Yes No Low Blood Pressure Yes No Low Blood Pressure Yes No Low Blood Transfusion Yes No Low Blood Pressure Yes No Radiation Treatment Yes No Psychiatric Problems Yes No Psychiatric Problems Yes No Radiation Treatment Yes No Radiation Treatment Yes No Radiation Treatment Yes No Scarlet Fever Yes No Sc				
Have you ever taken Phen-Fen?  Yes No (Also known as Redux or Pondimin) If yes, when?  Are you taking any medications for Osteoporosis?  No If so, what?  ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?  Aspirin Yes No Erythromycin Yes No Penicillin Yes No Jewelry/Metals Yes No Tetracycline Yes No Jewelry/Metals Yes No Tetracycline Yes No Dental Yes No Latex Yes No Other Yes No Anesthetics  Please list any other drugs/materials that you are allergic to:  HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?  Abnormal Bleeding Yes No Herpes/Fever Blisters Yes No High Blood Pressure Yes No High Blood Pressure Yes No Hilly + / AIDS Yes No Hospitalized Arthritis Yes No Hospitalized For any reason Yes No Kidney Problems Yes No Liver Disease Yes No Lupus Yes No Congenital Heart Defect Yes No Pacemaker Yes No Radiation Treatment Yes No Individual Problems Yes No Pacemaker Yes No Radiation Treatment Yes No Epilepsy Yes No Scarlet Fever Yes No Scarlet Fever Yes No Frequent Headaches Yes No Shingles Yes No Scarlet Fever Yes No Frequent Headaches Yes No Shingles Yes No Scarlet Fever Yes No Frequent Headaches Yes No Sickle Cell Disease Yes No S				
(Also known as Redux or Pondimin) If yes, when?  Are you taking any medications for Osteoporosis?	Please list each one:			
(Also known as Redux or Pondimin) If yes, when?  Are you taking any medications for Osteoporosis?				
Are you taking any medications for Osteoporosis?  Ves No If so, what?  ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?  Aspirin Yes No Erythromycin Yes No Penicillin Yes No Codeine Yes No Jewelry/Metals Yes No Other Yes No Dental Yes No Latex Yes No Other Yes No Anesthetics  Please list any other drugs/materials that you are allergic to:  HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?  Abnormal Bleeding Yes No Herpes/Fever Blisters Yes No Alcohol / Drug Abuse Yes No High Blood Pressure Yes No Anemia Yes No HIV+ / AIDS Yes No Arthritis Yes No Hospitalized Arthritical Bones, Joints, or Valves Yes No Asthma Yes No Liver Disease Yes No Cancer / Chemotherapy Yes No Low Blood Pressure Yes No Cancer / Chemotherapy Yes No Low Blood Pressure Yes No Cancer / Chemotherapy Yes No Low Blood Pressure Yes No Cancer / Chemotherapy Yes No Low Blood Pressure Yes No Cancer / Chemotherapy Yes No Low Blood Pressure Yes No Cancer / Chemotherapy Yes No Low Blood Pressure Yes No Cancer / Chemotherapy Yes No Low Blood Pressure Yes No Congenital Heart Defect Yes No Pacemaker Yes No Difficulty Breathing Yes No Radiation Treatment Yes No Emphysema Yes No Radiation Treatment Yes No Emphysema Yes No Radiation Treatment Yes No Emphysema Yes No Scizures Yes No Frequent Headaches Yes No Shingles Yes No Glaucoma Yes No Sickle Cell Disease Y				
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ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?  Aspirin Yes No Erythromycin Yes No Penicillin Yes No Dental Yes No Latex Yes No Other Yes No Pental Yes No Latex Yes No Other Yes No Pental Yes No Latex Yes No Other Yes No Pental Yes No Latex Yes No Other Yes No Pental Yes N	,			
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Aspirin Yes No Codeine Yes No Dental Yes No Dental Yes No Dental Yes No Latex Yes No Other Yes No Anesthetics  Please list any other drugs/materials that you are allergic to:  HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?  Abnormal Bleeding Yes No Herpes/Fever Blisters Yes No High Blood Pressure Yes No High Blood Pressure Yes No HIV+ / AIDS Yes No HIV+ / AIDS Yes No Hospitalized For any reason Yes No Liver Disease Yes No Liver Disease Yes No Low Blood Pressure Yes No Radiation Treatment Yes No Radiation Treatment Yes No Radiation Treatment Yes No Reumatic Yes No Reumatic Yes No Reumatic Yes No Scarlet Fever Yes N	ARE YO	U ALLE	ERGIC TO ANY	
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Please list any other drugs/materials that you are allergic to:  HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?  Abnormal Bleeding Yes No Herpes/Fever Blisters Yes No High Blood Pressure Yes No High Blood Pressure Yes No Hospitalized Arthritis Yes No Hospitalized For Valves Yes No Kidney Problems Yes No Asthma Yes No Liver Disease Yes No Low Blood Pressure Yes No Cancer/Chemotherapy Yes No Lupus Yes No Congenital Heart Defect Yes No Mitral Valve Prolapse Yes No Disbetes Yes No Radiation Treatment Yes No Republished Yes No Radiation Treatment Yes No Requested Yes No Recarded Yes No Recarded Yes No Recarded Yes No Recarded Yes No Scarlet Fever Yes No Frequent Headaches Yes No Sickle Cell Disease Yes No Glaucoma Yes No Sickle Cell Disease Yes No Yes				
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Arthritis Yes No Hospitalized for any reason Yes No Arthritis Yes No Kidney Problems Yes No Asthma Yes No Liver Disease Yes No Low Blood Pressure Yes No Lupus Yes No Lupus Yes No Lupus Yes No Lupus Yes No Mitral Valve Prolapse Yes No Pacemaker Yes No Pacemaker Yes No Pidibetes Yes No Pacemaker Yes No Pidibetes Yes No Radiation Treatment Yes No Rheumatic/ Yes No Radiation Treatment Yes No Repilepsy Yes No Scarlet Fever Yes No Frequent Headaches Yes No Sickle Cell Disease Yes No Gisckle Cell Disease Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI	OU EV	ER HAD ANY NG DISEASES C ROBLEMS?	)R
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or Valves Yes No Kidney Problems Yes No Asthma Yes No Liver Disease Yes No Low Blood Pressure Yes No Lupus Yes No Lupus Yes No Lupus Yes No Lupus Yes No Mitral Valve Prolapse Yes No Pacemaker Yes No Pacemaker Yes No Psychiatric Problems Yes No Radiation Treatment Yes No Radiation Treatment Yes No Repliepsy Yes No Scarlet Fever Yes No Seizures Yes No Seizures Yes No Scalaucoma Yes No Sickle Cell Disease Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia	OU EV LLOWI ICAL P Yes No Yes No Yes No	YER HAD ANY NG DISEASES C ROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS	Yes No
Blood Transfusion  Yes No Low Blood Pressure  Yes No Lupus  Colitis  Yes No Mitral Valve Prolapse  Yes No Pacemaker  Yes No Pacemaker  Yes No Psychiatric Problems  Yes No Radiation Treatment  Yes No Rheumatic/  Yes No Scarlet Fever  Yes No Seizures  Yes No Shingles  Yes No Sickle Cell Disease  Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis	OU EV LLOWI ICAL P Yes No Yes No Yes No	YER HAD ANY NG DISEASES OROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized	Yes No Yes No Yes No
Cancer / Chemotherapy Yes No Lupus Yes No Bitral Valve Prolapse Yes No Mitral Valve Prolapse Yes No Pacemaker Yes No Pacemaker Yes No Psychiatric Problems Yes No Radiation Treatment Yes No Rheumatic / Yes No Scarlet Fever Yes No Seizures Yes No Shingles Yes No Sickle Cell Disease Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves	OU EV LLOWI ICAL P Yes No Yes No Yes No Yes No	YER HAD ANY NG DISEASES C ROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems	Yes No Yes No Yes No Yes No Yes No
Colitis Yes No Mitral Valve Prolapse Yes No Congenital Heart Defect Yes No Pacemaker Yes No Pacemaker Yes No Psychiatric Problems Yes No Radiation Treatment Yes No Rheumatic/ Yes No Scarlet Fever Yes No Seizures Yes No Shingles Yes No Sickle Cell Disease Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma	YOU EV LLOWI ICAL P Yes No Yes No Yes No Yes No Yes No	/ER HAD ANY NG DISEASES C ROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease	Yes No Ye
Diabetes Yes No Psychiatric Problems Yes No Difficulty Breathing Yes No Radiation Treatment Yes No Rheumatic/ Yes No Scarlet Fever Yes No Seizures Yes No Sickle Cell Disease Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion	YOU EV LLOWI ICAL P Yes No Yes No Yes No Yes No Yes No Yes No Yes No	/ER HAD ANY NG DISEASES C ROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure	Yes No Ye
Difficulty Breathing Yes No Radiation Treatment Yes No Emphysema Yes No Rheumatic/ Yes No Epilepsy Yes No Scarlet Fever Yes No Frequent Headaches Yes No Shingles Yes No Glaucoma Yes No Sickle Cell Disease Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer/Chemotherapy	YOU ENLOWI ICAL P Yes No	/ER HAD ANY NG DISEASES C ROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus	Yes No
Emphysema Yes No Rheumatic/ Yes No Epilepsy Yes No Scarlet Fever Yes No Frequent Headaches Yes No Sickle Cell Disease Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer/Chemotherapy Colitis Congenital Heart Defect	YOU EV LLOWI ICAL P Yes No Yes No	/ER HAD ANY NG DISEASES OROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker	Yes No Ye
Epilepsy Yes No Scarlet Fever Yes No Fainting Spells Yes No Seizures Yes No Frequent Headaches Yes No Shingles Yes No Glaucoma Yes No Sickle Cell Disease Yes No	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer/Chemotherapy Colitis Congenital Heart Defect Diabetes	YOU EV LLOWI ICAL P Yes No Yes No	YER HAD ANY NG DISEASES OROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems	Yes No Ye
Frequent Headaches Yes No Seizures Yes No Shingles Yes No Sickle Cell Disease	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer / Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing	YOU EV LLOWI ICAL P Yes No Yes No	YER HAD ANY NG DISEASES OROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment	Yes No
Glaucoma Yes No Sickle Cell Disease Yes N	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer/Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing Emphysema	YOU EV LLOWI ICAL P Yes No Yes No	/ER HAD ANY NG DISEASES CROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/	Yes No
	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer/Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing Emphysema Epilepsy	YOU EV LLOWI ICAL P YES NO	/ER HAD ANY NG DISEASES CROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/ Scarlet Fever	Yes No
	HAVE YOF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer/Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing Emphysema Epilepsy Fainting Spells Frequent Headaches	Yes No	/ER HAD ANY NG DISEASES OROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/ Scarlet Fever Seizures Shingles	Yes No
	HAVE YOF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer / Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing Emphysema Epilepsy Fainting Spells Frequent Headaches Glaucoma	YOU ENLOWI ICAL P Yes No	/ER HAD ANY NG DISEASES C ROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/ Scarlet Fever Seizures Shingles Sickle Cell Disease	Yes No
	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer/Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing Emphysema Epilepsy Fainting Spells Frequent Headaches Glaucoma Hay Fever	YOU ENLOWI ICAL P Yes No	/ER HAD ANY NG DISEASES OROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/ Scarlet Fever Seizures Shingles Sickle Cell Disease Sinus Problems	Yes No
	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer/Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing Emphysema Epilepsy Fainting Spells Frequent Headaches Glaucoma Hay Fever Heart Attack	YOU ENLOWIIICAL P Yes No	/ER HAD ANY NG DISEASES OROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/ Scarlet Fever Seizures Shingles Sickle Cell Disease Sinus Problems Stroke	Yes No
Hemophilia Yes No Ulcers Yes N	HAVE Y OF THE FO MEDI Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer / Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing Emphysema Epilepsy Fainting Spells Frequent Headaches Glaucoma Hay Fever Heart Attack Heart Murmur	YOU EV LLOWI ICAL P Yes No	/ER HAD ANY NG DISEASES CROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/ Scarlet Fever Seizures Shingles Sickle Cell Disease Sinus Problems Stroke Thyroid Problems	Yes No
Hepatitis Yes No Venereal Disease Yes N	HAVE Y OF THE FO MEDI  Abnormal Bleeding Alcohol / Drug Abuse Anemia Arthritis Artificial Bones, Joints, or Valves Asthma Blood Transfusion Cancer / Chemotherapy Colitis Congenital Heart Defect Diabetes Difficulty Breathing Emphysema Epilepsy Fainting Spells Frequent Headaches Glaucoma Hay Fever Heart Attack Heart Murmur Heart Surgery Hemophilia	YOU EN LLOWI ICAL P Yes No	/ER HAD ANY NG DISEASES CROBLEMS?  Herpes/Fever Blisters High Blood Pressure HIV+ / AIDS Hospitalized for any reason Kidney Problems Liver Disease Low Blood Pressure Lupus Mitral Valve Prolapse Pacemaker Psychiatric Problems Radiation Treatment Rheumatic/ Scarlet Fever Seizures Shingles Sickle Cell Disease Sinus Problems Stroke Thyroid Problems Tuberculosis (TB) Ulcers	Yes No Ye

#### FOR WOMEN ONLY

Are you taking birth control pills?	☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No	Week #
Are you nursing? ☐ Yes ☐ No	

7	DENTAL HISTORY
Why have you	come to the dentist today?
2	r told you that you require antibiotics eatment? □ Yes □ No
Are you current	ly in pain? ☐ Yes ☐ No
2	had a serious/difficult problem associated with us dental work? $\ \square$ Yes $\ \square$ No
2	you ever experienced pain/discomfort t (TMJ/TMD)? ☐ Yes ☐ No
Your current de	ntal health is □ Good □ Fair □ Poor
Do you like you	ır smile? 🖵 Yes 🖵 No
Do your gums e	ever bleed? 🖵 Yes 🖵 No
How many time	es a week do you floss?
How many time	es a day do you brush?
Type of toothbr	ush bristles? 🗖 Hard 📮 Medium 📮 Soft

# (8)

#### DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I amy need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees and court costs.

Signature

Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

