

Home Address				Business / School Name	
City		State	Zip Code	Business / School Address	
Date of Birth	Sex	Height	Weight	Business / School Phone No.	Email Address:
Marital Status:		Social Security No.		In Case of Emergency: Name and Telephone No.	
Spouse / Parent : Name and Telephone No.				Referred By:	Best Way to Contact You:

Dental Insurance Information (Primary Carrier)				Dental Insurance Information (Secondary Carrier)			
Insured's Name (Last)		(First)	(Middle)	Insured's Name (Last)		(First)	(Middle)
Insurance Company				Insurance Company			
Insurance Company Address				Insurance Company Address			
Insured's Employer		Insured's Soc. Sec. No.		Insured's Employer		Insured's Soc. Sec. No.	
Insured's DOB	ID No.		Group No.	Insured's DOB	ID No.		Group No.

Health History			
Physician's Name		Phone No.	Address
Date of Last Physical		Blood Pressure	Pulse
			Are you Pregnant?

Are you ALLERGIC or have you experienced any reaction to the following?

	Yes	No		Yes	No		Yes	No
Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/Sedatives/Sleeping Pills.....	<input type="checkbox"/>	<input type="checkbox"/>	Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>	Metal.....	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics (Penicillin, Amoxicillin etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	Acrylic.....	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies:.....		

Are you taking any of the following:

	Yes	No		Yes	No		Yes	No
Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergy / Cold Remedies.....	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/ Heart Meds.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinners.....	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills.....	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Tranquillizers.....	<input type="checkbox"/>	<input type="checkbox"/>	Baby Aspirin 81mg.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Insulin / Diabetic Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin 325mg.....	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone / Steroids.....	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis Medication.....	<input type="checkbox"/>	<input type="checkbox"/>

List any and ALL medications you are currently taking:.....

Indicate which of the following you have had or have at the present:

	Yes	No		Yes	No		Yes	No
Heart Failure.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints (Hip/ Knee).....	<input type="checkbox"/>	<input type="checkbox"/>	Chemo Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious).....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum).....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C (Infectious).....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Jaw Joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Bruise Easily.....	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
						Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>

Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so explain:.....
