

MEDICAL INFORMATION

REFERRED BY \_\_\_\_\_ EMAIL \_\_\_\_\_

NAME \_\_\_\_\_ MALE FEMALE

DATE OF BIRTH \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SPOUSE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SPOUSE PLACE OF EMPLOYMENT \_\_\_\_\_

METHOD OF PAYMENT CASH INSURANCE CARECREDIT

INSURANCE COMPANY \_\_\_\_\_ ID OR SS# \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_

PHYSICIAN NAME AND NUMBER \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_

FOR THE FOLLOWING QUESTIONS CIRCLE YES OR NO

ARE YOU IN GOOD HEALTH YES NO

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR YES NO

ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO

IF YES, WHAT CONDITION ARE YOU BEING TREATED FOR? \_\_\_\_\_

HAVE YOU EVER HAD ANY SERIOUS ILLNESS, SURGERY OR HAVE BEEN HOSPITALIZED IN THE  
LAST 2 YEARS YES NO

IF YES, EXPLAIN \_\_\_\_\_

HAVE YOU EVER HAD HEART SURGERY, AN ARTIFICIAL HEART VALVE, OR BACTERIAL ENDO  
CARDITIS YES NO IF YES, EXPLAIN \_\_\_\_\_

\_\_\_\_\_

TURN OVER TO FINISH

CIRCLE ANY ILLNESSES THAT YOU HAVE OR HAVE HAD

HIGH BLOOD PRESSURE LOW BLOOD PRESSURE PACEMAKER

MEDICAL INFORMATION

HAYFEVER

RESPIRATORY PROBLEMS

ASTHMA IF SO WHAT TRIGGERS ATTACKS \_\_\_\_\_

FAINING SPELLS SIEZURES OR EPILEPSY, IF SO WHEN WAS LAST SIEZURE \_\_\_\_\_

DIABETES HEPATITIS AIDS OR HIV INFECTION THYROID PROBLEMS

TUBERCULOSIS CANCER CHEMO RADIATION

ARE YOU CURRENTLY RECEIVING CHEMO OR RADIATION

ABNORMAL BLEEDING BISPHOSPHONATES OR BONE BUILDING MEDICINE

ARTIFICIAL JOINTS, IF SO DATE OF SURGERY \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALLERGIES \_\_\_\_\_

HAVE YOU HAD TROUBLE WITH PREVIOUS DENTAL TREATMENT \_\_\_\_\_

DO YOU CURRENTLY USE TOBACCO YES NO IF SO WHAT KIND \_\_\_\_\_

ARE YOU PREGNANT YES NO

DO YOU STILL HAVE YOUR TONSILS AND ADENOIDS YES NO

DO YOU SNORE YES NO ARE YOU SLEEPY DURING THE DAY YES NO

HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA YES NO IF SO, DO YOU USE A CPAP YES NO

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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