PERSONAL HISTORY

MR.
MRS.
MS.
MISS _____ Birthdate _____ SS# _____
Patient's Last Name First Initial

Referred by _____

Home Address _____ City _____ Zip _____ Phone _____
Occupation _____ Employer _____
Work Address _____ City _____ Zip _____ Wk. Phone _____
Dental Insurance YES NO NAME and Address of Insurance _____
Spouses Name _____ Spouse's Employer _____ SP. Wk. Phone _____
If Patient Is A Minor- Person Financially Responsible _____ Relationship To You _____
Closest Relative other than Spouse Name _____ Phone _____

Medical/Dental History _____

Medical Doctor _____ Address _____ Phone _____
Are you in good health? _____ If no, explain _____
Do you bleed excessively when cut? _____ Do you smoke? _____
Are you taking any medication, pills or drugs? _____ Please list _____
Do you have any allergies? _____ Please list _____
Do you now have or have you had any of the following?

	YES	NO		YES	NO
1. HEART DISEASE	_____	_____	10. TUMOR HISTORY	_____	_____
2. HIGH BLOOD PRESSURE	_____	_____	11. PROLAPSED MITRAL VALVE	_____	_____
3. BLOOD DISEASE	_____	_____	12. RADIATION TREATMENT	_____	_____
4. RHEUMATIC FEVER	_____	_____	13. HEPATITIS	_____	_____
5. HEART MURMUR	_____	_____	14. ASTHMA	_____	_____
6. DIABETES	_____	_____	15. TUBERCULOSIS	_____	_____
7. STROKE	_____	_____	16. AIDS/HIV	_____	_____
8. EPILEPSY	_____	_____	17. ARE YOU PREGNANT	_____	_____
9. ARTHRITIS	_____	_____			

Do you have any disease, condition or problem not listed above that you think we should know about? _____
If so, explain _____
Do you have any present dental complaints? _____
Have you had any serious troubled associated with previous dental treatment? _____
If so, explain _____

	YES	NO
Are any of your teeth sensitive to hot, cold or sweets?		
Do you grind or clench your teeth?	_____	_____

What would you like to change most about the appearance of the teeth? _____

REMARKS _____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient. I also agree to assume full financial responsibility for all treatment.

Signature _____ Date _____