PATIENT: _____

1. Have you been a patient in the hospital during the past two years? .....YES NO

2. Have you been under the care of a medical doctor during the past two years?.....YES NO

Physician's Name_____

Phone Number _____

Address _____

3. Are you now taking any medication, drugs, or pills? .....YES NO

If yes, please list:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

3. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? .....YES NO

If yes, please list:_____

_____

5. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item:

Heart failure	YES	NO	Emphysema	YES	NO
Heart Disease or Attack	YES	NO	Allergies or Hives	YES	NO
Angina Pectoris (Chest Pain)	YES	NO	Radiation Therapy	YES	NO
Congenital Heart Disease	YES	NO	Chemotherapy	YES	NO
Heart Murmur	YES	NO	Hepatitis A (infectious)	YES	NO
High blood Pressure	YES	NO	Hepatitis B (serum)	YES	NO
Arteriosclerosis	YES	NO	A.I.D.S.	YES	NO
Mitral Valve Prolapse	YES	NO	H.I.V. Positive	YES	NO
Artificial Heart Valve	YES	NO	Cold Sores/Fever Blisters	YES	NO
Heart Pacemaker	YES	NO	Blood Transfusion	YES	NO
Heart Surgery	YES	NO	Hemophilia	YES	NO
Rheumatic Fever	YES	NO	Anemia	YES	NO
Arthritis	YES	NO	Sickle Cell Disease	YES	NO
Rheumatism	YES	NO	Bruise Easily	YES	NO
Cortisone Medicine	YES	NO	Liver Disease	YES	NO
Drug Addiction	YES	NO	Yellow Jaundice	YES	NO
Stroke	YES	NO	Epilepsy or Seizures	YES	NO
Artificial Joints (hip, knee, etc.)	YES	NO	Fainting or Dizzy Spells	YES	NO
Kidney Trouble	YES	NO	Nervousness	YES	NO
Ulcers	YES	NO	Psychiatric Treatment	YES	NO
Diabetes	YES	NO	Developmentally Disabled	YES	NO
Thyroid Problems	YES	NO	Asthma	YES	NO
Glaucoma	YES	NO	Tuberculosis	YES	NO
Venereal Disease	YES	NO	Chronic Cough	YES	NO

6. Do you ever wake up from sleep and feel short of breath?.....YES NO

7. Has your medical doctor ever said you have a cancer or tumor?.....YES NO

8. Do you have or have you had any disease, condition, or problem not listed?.....YES NO

If yes, please list: _____

9. Do you have a latex allergy?.....YES NO

10. Do have have an allergy to nickel?.....YES NO

WOMEN ONLY:

Are you pregnant? .....YES NO

If yes, what month?_____

Are you nursing? .....YES NO

Are you taking birth control pills? .....YES NO

Dental History:

1. When was your last dental visit? _____
2. Was your last dental visit a good experience? .....YES NO
3. Do your gums bleed when you are brushing or flossing? .....YES NO
4. Are any of your teeth sensitive to hot, cold, or sweets? .....YES NO
5. Are you happy with your smile? .....YES NO
6. Would you like your teeth whiter? .....YES NO
7. Do you have any pain in your mouth? .....YES NO
8. Are your jaws tired when you wake up, or do your jaws ever hurt? .....YES NO
9. Do you ever feel you have bad breath? .....YES NO

I understand this information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

_____ _____

Patient Signature Date

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

_____ _____

Patient Date

_____ _____

Parent or Responsible Party Relationship

_____ _____

Witness Date