PATIENT NAME_____**DATE**_____

Birth Date_____ How do you prefer to be addressed? _____

Place of employment/occupation_____

NEW PATIENTS ONLY

Reason for this appointment_____

Who can we thank for referring you to our office_____

Do you have dental exams on a routine basis_____Last visit_____

Do you think you have gum disease?_____Do your gums bleed?_____

MEDICAL HISTORY

Name of your Physician_____ Last visit date_____

Name of Pharmacy _____

YES NO **Any new illness or surgery in last 3 years**? **Please list**: _____

Please list any prescription medications:_____

_____

_____

Please list over the counter medications:_____

YES NO Any Allergies? Please list:

YES NO Do you use any tobacco products?

YES NO Are you pregnant?

Do you have or have you ever had:

YES	NO	Rheumatic Fever	YES	NO	**Chemo or radiation therapy:DATE**_____
YES	NO	Heart Problems	YES	NO	**Joint Replacement**
YES	NO	Chest Pains			**Type/Date**:_____
YES	NO	Swelling of feet/ankles	YES	NO	**Cancer**
YES	NO	Osteoporosis			**Type/Date**:_____
YES	NO	Shortness of breath	YES	NO	Kidney or bladder trouble
YES	NO	High blood pressure	YES	NO	Arthritis
YES	NO	Stomach problems	YES	NO	Convulsions or seizures
YES	NO	Colitis	YES	NO	Endocrine disturbances
YES	NO	Bleeding problems	YES	NO	Psychological or emotional problem
YES	NO	Liver problems or hepatitis	YES	NO	Venereal disease
YES	NO	Glaucoma	YES	NO	Tuberculosis
YES	NO	Drug reactions	YES	NO	Severe headaches
YES	NO	Hay fever	YES	NO	Aids (HIV virus)
YES	NO	Asthma	YES	NO	Sinus trouble
YES	NO	Ulcers	YES	NO	Diabetes

Do you have or have had any condition, disease or problem not listed? Please list:

_____

X_____DATE_____

Patient Signature (Parent or Guardian if under 18)

X_____

Update signature/date/hygiene initial

X_____

Update signature/date/hygiene initial