Your health history is very important to us. In order that we may provide you with the best possible dental services, please answer all questions completely and accurately as incorrect information may compromise your treatment.

Date ____________________ **Last Name** ___________________________**First Name**_______________________

Health History

Are you currently under the care of a physician? (circle) Yes No

Reason for last visit to your physician? ____

Date of last physical examination ____/______/______ **Physician's Name** ________________________________

Past Medical History

1. Have you ever had a serious illness, operation, or been hospitalized? If so, please explain:

____

2. Has there been any change in your health in the last two (2) years? (circle) Yes No

If yes, please explain: ____

3. Have you ever had an allergic reaction? To: (circle) Medication Food Latex Products Other:

____

4. Have you ever had or been treated for: (circle all that apply):

Blood Pressure: High or Low	Heart Valve	Immunocompromised Disease
Artificial Joint	Fibromyalgia	Asthma
Heart Disease	Hepatitis	Bleeding/Clotting Disorder
Stroke	Diabetes	Dry Mouth
Rheumatic Fever	Depression	Osteoporosis
Heart Murmur	Tuberculosis	Other:_____________________

5. Do you now or have you ever used tobacco? (circle) Yes No

6. Have you been told you should take a premedication antibiotic before dental treatment? (circle) Yes No

7. **Have you ever been treated or diagnosed for sleep apnea, use/have used a CPAP machine?**(circle) Yes No

7. **For women**: a. Are you pregnant or do you think you may be pregnant? (circle) Yes No

b. Are you taking birth control pills? (circle) Yes No

Current Medications: Prescribed *and* Over-the-Counter

If you have a list with you, we can make a copy of that.

____________________________________ ____

____________________________________ ____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status.

Patient Signature______________________________________ Date ____

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print____Relationship____________________________________

Signature ____ Date ____

Acquaintance Forms

In this section are forms our office considers very important. If you have any changes to this information in the future, please notify us as soon as possible.

General Information

Last Name_____________________ First Name________________________ Initial________

Address_____________________________ City________________ State____ Zip________

Home Phone________________ Work Phone________________ Wireless _____________

Email Address____

How should we contact you? Circle your preference please.

Appointments: Text Email Call

Cleaning reminders: Text Email Call

Date of Birth ________________ Social Security Number________________________

Marital Status________________

Employer/School________________________________Occupation_______________

Whom may we thank for your referral? ______________________________________

Dental Insurance Information Please present Dental Insurance card for photo copy.

Emergency Notification Information

In case of emergency, who should be notified?

Name ____________________ Address _____________________ Phone___________

Please sign that you received our Privacy Policy

____