



Welcome to our office. Please take a few moments to complete this form. This will help us get to know you better, so that we may provide the best care for your particular needs.

Name _____ Birthdate _____ Age _____

Reason for your visit _____

	Yes	No
Are you in good health now	<input type="checkbox"/>	<input type="checkbox"/>
Are you now under the care of a physician?.....	<input type="checkbox"/>	<input type="checkbox"/>

If so, what condition(s) is being treated? _____

If you use tobacco (smoke/smokeless), indicate how much. _____

If you drink alcoholic beverages, indicate how much. _____

If you are pregnant, please give the due date. _____

Do you have or have you had any of the following?

	Yes	No		Yes	No
Marked Weight Change.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains/discomfort	<input type="checkbox"/>	<input type="checkbox"/>
Eruption (rash) hives	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat.....	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery.....	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/liver problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Immune problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding/bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>

Please list all medications and supplements you are currently taking. _____

Are you allergic to any medications? If so, please list. _____

Have you ever had surgery or a serious medical illness? If so, please describe. _____

Is there any disease, condition or problem not listed that you think we should know about, or is there any activity your doctor says you cannot do? If so, please explain. _____

Physician's Name _____

Phone #: _____

Dentist's Name _____

Phone #: _____

Does dental treatment make you nervous? No ____ Slightly ____ Moderately ____ Extremely ____

Do you have any of the following problems?

	Yes	No		Yes	No
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty opening or closing jaws	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal (gum) disease	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>

If there are any changes, please inform our office as soon as possible.

To the best of my knowledge, my answers are true and correct.

Signature of Patient, or Legal Guardian _____ Date _____