PATIENT MEDICAL HISTORY:

Medical Physician Office Phone

Approximate date of last appointment

Are you under any medical treatment now?

Have you had any major operations? If so what?

Have you ever had a serious accident involving head injuries?

Have you had adverse response to any drugs including penicillin?

Do you have night sweats accompanied by weight loss or cough?

Are you on a diet at this time?

List any medications you are currently taking.

Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?

Are you in general good health at this time?

Are you pregnant?

Do you have a history of fainting?

Have you ever had and X-RAY TREATMENTS (other than diagnostic)?

Has a physician ever informed you that you had:

A Heart Ailment?	Rheumatic Fever?	Any Stomach or Intestinal Disease?
High Blood Pressure?	Rheumatism or Arthritis?	Any Venereal Disease?
Respiratory Disease?	Tumors or Growths?	AIDS?
Asthma?	Any Blood Disease?	Yellow Jaundice or Hepatitis?
Any Liver Disease?	Any Kidney Disease?	Diabetes?

PATIENT DENTAL HISTORY:

Do you have any pain in your ears?

Do you have any unhealed injuries or inflamed areas in or around you mouth?

Have you experienced any growth or sore spots in your mouth?

Does any part of your mouth hurt when clenched?

Do your gums bleed?

Do you habitually clench your teeth during the night or day?

When was your last full mouth X-Ray taken? Where?

PATIENT DENTAL INSURANCE:

Primary Insurance company name:

Group/Policy #

Policy owner's Birthdate: Policy owner's SS#

Secondary Insurance company name:

Group/Policy #

Policy owner's Birthdate: Policy owner's SS#