11/08

ADULT

Name _____ Date of Birth _____

Nickname or preferred name _____ Home Phone _____

Street address_____ City & Zip code _____

E-mail _____ Cell Phone _____

Your Employer_____ Your work phone_____

Your Social Security Number _____ Your Dental Plan _____

Spouse's Name _____ Spouse's Date of Birth_____

Spouse's Social Security Number_____ Spouse's Cell Phone _____

Spouse's Employer _____ Spouse's Work Phone _____

Spouse's Dental Plan_____

Who can we thank for telling you about our office? _____

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

YES	NO	YES	NO	YES	NO
___	___ **Latex reaction**	___	___ **Allergy to Anesthetics**	___	___ Cancerous/Noncancerous growth
___	___ **Heart Murmur**	___	___ Phlebitis	___	___ Radiation treatment
___	___ **Rheumatic Fever**	___	___ Diabetes	___	___ Chemotherapy
___	___ **Artificial Heart Valve**	___	___ Hypoglycemia	___	___ Anemia
___	___ **Artificial Joint or Bone**	___	___ Thyroid Disorder	___	___ Varicosities
	Replacement	___	___ Kidney Disorder	___	___ Seizures, Fainting, Epilepsy
___	___ **Heart Surgery**	___	___ Hepatitis – If yes,	___	___ Asthma, Emphysema
___	___ **Mitral Valve Prolapse**		what type?	___	___ Tuberculosis
___	___ **Current Pregnancy**		___ A	___	___ Ulcer
___	___ **Any heart disease**		___ B	___	___ Bladder Problem
___	___ **Organ Transplant**		___ C	___	___ Measles or mumps
___	___ **Breast Augmentation**	___	___ Jaundice/Liver Disorders	___	___ Hearing Problem
___	___ High Blood Pressure	___	___ Glaucoma	___	___ **HIV positive**
___	___ Low Blood Pressure	___	___ Arthritis, Physical Disability	___	___ Venereal Disease
___	___ Circulatory Problems	___	___ Nervous Problems	___	___ Blood Transfusions
___	___ Stroke	___	___ Psychiatric Care	___	___ Blood Disorder
___	___ **Abnormal Bleeding**	___	___ Frequent Headaches	___	___ Persistent cough with
	(Hemophilia)	___	___ Sinus Problems		phlegm or blood
___	___ Developmentally disabled	___	___ Respiratory Diseases	___	___Home drinking water is well water
___	___Stent (Heart or neurological)		___Osteoporosis		

Usual Blood Pressure (if known) _____/_____

Please list any medications you are taking and reasons for taking them (***please note if you take Fosamax, Actonel, Boniva; Coumadin or other blood-thinners***)

_____

Supplements: Vitamins, Herbal, etc. (list)_____

Please list any allergies, especially to medication _____

In the last five years I have been hospitalized for _____

Name of family physician _____

Current dental concerns _____

Other pertinent information _____

_____

Signature _____ Date _____