ADULT

Name _____ Date of Birth _____

Nickname or preferred name _____ Home Phone _____Cell Phone_____

Street address_____ City & Zip code _____

E-mail _____ Work Phone:_____

Your Employer_____ Your Dental Plan_____

Your Social Security Number _____ Driver License #_____

Spouse's Name _____ Subscriber I.D._____Group #_____

Spouse's Social Security Number_____ Spouse's Cell Phone _____Work Phone_____

Spouse's Employer _____ Spouse's Date of Birth ___ _____

Spouse's Dental Plan_____ Subscriber I.D._____Group #_____

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 growth
						___	___	Non-cancerous growth
___	___	**Heart Murmur**	___	___	Respiratory Disease	___	___	Radiation treatment
			___	___	Diabetes	___	___	Chemotherapy
___	___	**Artificial Heart Valve**	___	___	Hypoglycemia	___	___	Anemia
___	___	**Artificial Joint or Bone**	___	___	Thyroid Disorder	___	___	Prone to cold sores
		Replacement	___	___	Kidney Disorder	___	___	Seizures, Fainting, Epilepsy
___	___	**Heart Surgery**	___	___	Hepatitis – If yes,	___	___	Stent (Heart or neurological)
___	___	**Mitral Valve Prolapse**			what type?	___	___	Tuberculosis
___	___	**Current Pregnancy**			___ A	___	___	Ulcer
___	___	**Any heart disease**			___ B	___	___	Asthma, Emphysema
___	___	**Organ Transplant**			___ C	___	___	Acid reflux/Gerd
			___	___	Jaundice/Liver Disorders	___	___	Hearing Problem
___	___	High Blood Pressure	___	___	Glaucoma	___	___	**HIV positive**
___	___	Low Blood Pressure	___	___	Arthritis, Physical Disability	___	___	Osteoporosis
___	___	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				___	___	Home drinking water is well water
		Disabled			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***)

_____

Please note anything you have been diagnosed with that is not listed above: _____

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 _____

Signature _____ Date _____