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Welcome to our practice! In maintaining our philosophy of excellence in dentistry it is important that you provide us with an accurate dental and medical history. Thank you for your cooperation.

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ *Drivers Lic.#:* \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ BUSINESS TELEPHONE: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ BUSINESS TELEPHONE: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

ACCOUNT TO BE PAID BY: CHECK  CHARGE CARD  CASH  CARECREDIT

DO YOU HAVE DENTAL INSURANCE? YES  NO

**HEALTH HISTORY**

ARE YOU UNDER THE CARE OF A MEDICAL DOCTOR AT PRESENT? ..... YES  NO

PHYSICIAN'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS, DRUGS, PILLS? LIST INDIVIDUALLY NAME AND USE. IF EXTENSIVE LIST PLEASE USE ATTACHED FORM.

NAME _____	USE _____
NAME _____	USE _____
NAME _____	USE _____
NAME _____	USE _____
NAME _____	USE _____

MEDICATIONS UPDATE:

DATE _____	NAME _____	USE _____
DATE _____	NAME _____	USE _____
DATE _____	NAME _____	USE _____
DATE _____	NAME _____	USE _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ..... YES  NO

PENICILLIN  ASPIRIN  CODEINE  ERYTHROMYCIN  LATEX

ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATION OR SUBSTANCE (IE LATEX)? .....

WOMEN: ARE YOU PREGNANT? IF YES, HOW MANY MONTHS? \_\_\_\_\_

