HEALTH INFORMATION:

YES NO 1. Are you currently under the care of a physician?
YES NO 2. Are you allergic to any medications? Please List
____
YES NO 3. Have you ever had rheumatic fever?
YES NO 4. Have you ever had a heart murmur or mitral valve prolapse?
YES NO 5. Have you ever had a prosthetic joint? (knee, hip, Etc.) or prosthetic heart valve?
YES NO 6. Have you ever had a tumor or cancer?
YES NO 7. Have you ever received chemotherapy or radiation treatment?
YES NO 8. Do you have high or low blood pressure?
YES NO 9. Have you ever had angina pectoris or a heart attack?
YES NO 10. Have you ever had hepatitis?
YES NO 11. Do you have diabetes?
YES NO 12. Have you ever had seizures, convulsions, or epilepsy?
YES NO 13. Do you have any blood disorder (anemia, hemophilia, etc,) ?
YES NO 14. Have you ever tested positive for HIV?
YES NO 15. Have you ever had syphilis, gonorrhea, or herpes?
YES NO 16. If female, are you pregnant?
YES NO 17. Do you suffer from sinusitis, hay fever, or asthma?
YES NO 18. Have you ever had any kidney or bladder disorder?
YES NO 19. Have you ever been hospitalized or had any major illness?
YES NO 20. Do you have any unusual noises or pain in your jaw joints?
YES NO 21. Do you grind or clench your teeth?
YES NO 22. Would you like to improve the appearance of your smile?
YES NO 23. Do your gums bleed?
YES NO 24. Do you fear dental treatment?
YES NO 25. Are your teeth sensitive to cold, hot, air, or sweets?
YES NO 26. Are you presently experiencing pain from your mouth or teeth?
YES NO 27. Is there any other condition about which we should know?
YES NO 28. Are you presently taking medications? Please list
____
YES NO 29. Do you use tobacco?
YES NO 30. Do you play any sports?
YES NO 31. Do you believe you have bad breath?
YES NO 32. Do you have any metal (nickel, gold, etc.) allergies?
YES NO 33. Would you be available on short notice for your appointment?

In case of emergency, whom should we notify?
Name______________________________________Phone_________________ Relation___________

I affirm that all information on this form is correct. I consent to dental examination, x-rays, and treatment.

____ __________________________________
Signature (patient, parent, guardian) Date