## HEALTH HISTORY (PLEASE PRINT)

Sponses Name Driver's License # S.S.# /	Patient Name	Γ	Oriver's License#_		S.S.#	/
Birthdate / Former Patient? Yes / No Male/Female Are you: Single / Married / Divorced / Widows   Employer/School	Spouses Name	I	Driver's License#_		S.S.#	//
Birthdate	Address	(	City		Zip	
Employer/School Occupation Business Address Telephone ( )  Spouse's Employer Telephone ( )  Physician's Name Telephone ( )  Are you presently being treated by a Physician? Yes / No Reason Who may we thank for referring you?  LIST ALL MEDICINES, PILLS OR DRUGS YOU ARE NOW TAKING (prescription and over the counter): Name of Drug How often taken each day Purpose of drug or disease being treated by a Physician? Yes / No Pacemaker Yes / No Yes / No Knee or any Joint prosthesis Yes / No WHEN WHEN WHEN WHEN DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:  WHEN WHEN WHEN WHEN Congenital Heart Disease Yes / No Liver Disease Yes / No Congenital Heart Disease Yes / No Liver Disease Yes / No Wery high fever with disease Yes / No Diabetes Yes / No Glaucoma Yes / No High / Low Blood Pressure Yes / No Glaucoma Yes / No Nervous Disorder Yes / No Phoeumonia Yes / No Wery high fever with disease Yes / No High / Low Blood Pressure Yes / No Glaucoma Yes / No Phoeumonia Yes / No Wery high fever with disease Yes / No Wery on Stidney Problems Yes / No Phoeumonia Yes / No Wery on Stidney Problems Yes / No Disorder Yes / No Diso	Home Phone		Cell Pho	ne		
Business Address	Birthdate/ Form	er Patient? Yes /	No Male/Female A	re you: Single	/ Married /	Divorced / Widowe
Spouse's Employer	Employer/School		Occupation			
Physician's Name	Business Address			Telephone (_	)	
Are you presently being treated by a Physician? Yes / No Reason  Who may we thank for referring you?  LIST ALL MEDICINES, PILLS OR DRUGS YOU ARE NOW TAKING (prescription and over the counter): Name of Drug How often taken each day Purpose of drug or disease being treated  BO YOU CURRENTLY HAVE: Heart Murmur Yes / No Pacemaker Yes / No WHY (with or without regurgitation) Yes / No Knee or any Joint prosthesis Yes / No WHEN WHEN  Heart trouble Yes / No Ulcers Yes / No Jaundice Yes / No Liver Disease Yes / No Congenital Heart Disease Yes / No Arthritis Yes / No Whey rey high fever with disease Yes / No Diabetes Yes / No High / Low Blood Pressure Yes / No Nervous Disorder Yes / No Asthma, Hay fever, Allergies Yes / No Nervous Disorder Yes / No Bronchitis Yes / No Urinating Problems Yes / No Bronchitis Yes / No Excessive Urination Yes / No Constant Cough Yes / No Diabetes Yes / No Constant Cough Yes / No Diabetes Yes / No Constant Cough Yes / No Diabetes Yes / No Constant Touble Yes / No Diabetes Yes / No	Spouse's Employer			Telephone (_	_)	
Who may we thank for referring you?  LIST ALL MEDICINES, PILLS OR DRUGS YOU ARE NOW TAKING (prescription and over the counter): Name of Drug How often taken each day Purpose of drug or disease being treated  WHEN  Heart trouble  Yes / No  Liver Disease Yes / No  Glaucoma Yes / No  Asthma, Hay fever with disease Yes / No  Asthma, Hay fever with disease Yes / No  Purpose Disease Yes / No  Asthma, Hay fever, Allergies Yes / No  Purpose Disease Yes / No  Sinus Trouble Yes / No  Back Injury Yes / No  Purpose No Hiv Positive Yes / No  Shortness of Breath Yes / No  Sphilis, Herpes Yes / No	Physician's Name			Telephone (_	)	
LIST ALL MEDICINES, PILLS OR DRUGS YOU ARE NOW TAKING (prescription and over the counter):    Name of Drug	Are you presently being treated	by a Physician?	Yes / No Reason _			
Name of Drug  How often taken each day  Purpose of drug or disease being treated  Purpose of drug or disease being treated and and park treated a	Who may we thank for referring	g you?				
DO YOU CURRENTLY HAVE: Heart Murmur Yes / No Pacemaker Yes / No MVP (with or without regurgitation) Yes / No Knee or any Joint prosthesis Yes / No  DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:  WHEN WHEN  Heart trouble Yes / No Ulcers Yes / No Jaundice Yes / No Tumor or Cancer Yes / No Congenital Heart Disease Yes / No Arthritis Yes / No Very high fever with disease Yes / No Diabetes Yes / No High / Low Blood Pressure Yes / No Nervous Disorder Yes / No Pneumonia Yes / No Kidney Problems Yes / No Bronchitis Yes / No Urinating Problems Yes / No Donstant Cough Yes / No Excessive Urination Yes / No Constant Cough Yes / No Anemia Yes / No Emphysema Yes / No Hemophilia Yes / No Emphysema Yes / No Hemophilia Yes / No Epilepsy Yes / No Back Pain Yes / No Shortness of Breath Yes / No Stroke Yes / No Swelling of Ankles Yes / No Bronches Yes / No Epilepsy Yes / No Back Pain Yes / No Swelling of Ankles Yes / No Stroke Yes / No Syphilis, Herpes Yes / No Sponthess of Breath Yes / No Syphilis, Herpes Yes / No Spontness of Breath Yes / No Syphilis, Herpes Yes / No Strovole Yes / No Spontness of Breath Yes / No Syphilis, Herpes Yes / No Strovole Yes / No Strovole Yes / No Spontness of Breath Yes / No Syphilis, Herpes Yes / No Strovole Yes /	Name of Drug	How often take	en each day	Purpose of dru	g or disease	being treated
WHEN  Heart trouble Yes / No Ulcers Yes / No Jaundice Yes / No Liver Disease Yes / No Liver Disease Yes / No Liver Disease Yes / No Diabetes Yes / No Diabetes Yes / No Diabetes Yes / No Strooke Yes / No Diabetes Yes / No Diabete	DO YOU CURRENTLY HAVE Heart Murmur Pacemaker MVP (with or without regurgita	Yes / N Yes / N Ation) Yes / N	No No			
Heart trouble Yes / No Ulcers Yes / No Jaundice Yes / No Tumor or Cancer Yes / No Congenital Heart Disease Yes / No Liver Disease Yes / No Network Diabetes Yes / No Diabetes Yes / No Diabetes Yes / No Diabetes Yes / No Nervous Disorder Yes / No Nervous	DO YOU HAVE OR HAVE YO	U EVER HAD A	ANY OF THE FOLI	LOWING:		
Jaundice Yes / No Tumor or Cancer Yes / No Liver Disease Yes / No Diabetes Yes / No Dia						
Congenital Heart Disease Yes / No Liver Disease Yes / No Rheumatic Heart Disease Yes / No Arthritis Yes / No Diabetes Yes / No Diabetes Yes / No High / Low Blood Pressure Yes / No Glaucoma Yes / No Asthma, Hay fever, Allergies Yes / No Nervous Disorder Yes / No Nervous Disorder Yes / No Revous Disorder Yes / No Diabetes Yes / No Nervous Disorder Yes / No Diabetes / Yes / No Diabetes / Yes / No Diabetes / Yes / No Diabetes					Yes / No _	
Rheumatic Heart Disease Yes / No					Yes / No _	
Rheumatic Heart Disease Yes / No	9	Yes / No	Liver Dis		Yes / No _	
Very high fever with disease Yes / No		Yes / No	Arthritis		Yes / No _	
Asthma, Hay fever, Allergies Yes / No		Yes / No	Diabetes		Yes / No _	<del></del>
Pneumonia Yes / No		Yes / No	Glaucom		Yes / No _	
Pneumonia Yes / No		Yes / No	Nervous		Yes / No _	
Bronchitis Yes / No Urinating Problems Yes / No Excessive Urination Yes / No Excessive Urination Yes / No Excessive Urination Yes / No Excessive Thirst Yes / No Emphysema Yes / No Anemia Yes / No Hemophilia Yes / No Sinus Trouble Yes / No Other Blood Disorder Yes / No Epilepsy Yes / No Back Injury Yes / No High / Low Blood Sugar Yes / No Back Pain Yes / No Stroke Yes / No Swelling of Ankles Yes / No HIV Positive Yes / No Shortness of Breath Yes / No Syphilis, Herpes Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No Gonorrhea		Yes / No	Kidney P		Yes / No	
Tuberculosis or Lung Diseases Yes / No		Yes / No	Urinating		Yes / No _	
Constant Cough Yes / No Excessive Thirst Yes / No Emphysema Yes / No Anemia Yes / No Hemophilia Yes / No Sinus Trouble Yes / No Other Blood Disorder Yes / No Epilepsy Yes / No Back Injury Yes / No High / Low Blood Sugar Yes / No Stroke Yes / No Swelling of Ankles Yes / No HIV Positive Yes / No Shortness of Breath Yes / No Syphilis, Herpes Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No Gonorrhea Yes / No Gonorrhea	<b>Tuberculosis or Lung Diseases</b>	Yes / No	Excessive		Yes / No _	
Emphysema Yes / No Anemia Yes / No Hemophilia Yes / No Sinus Trouble Yes / No Other Blood Disorder Yes / No Epilepsy Yes / No Back Injury Yes / No High / Low Blood Sugar Yes / No Stroke Yes / No Swelling of Ankles Yes / No HIV Positive Yes / No Shortness of Breath Yes / No Syphilis, Herpes Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No Gonorrhea Yes / No Gonorrhea		Yes / No	Excessive	e Thirst	Yes / No _	
Tobacco or Alcohol Habit Yes / No Hemophilia Yes / No Other Blood Disorder Yes / No Blood Disorder Yes / No Back Injury Yes / No Back Pain Yes / No Stroke Yes / No HIV Positive Yes / No HIV Positive Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes /		Yes / No	Anemia		Yes / No	
Sinus Trouble Yes / No Other Blood Disorder Yes / No Epilepsy Yes / No Back Injury Yes / No Back Pain Yes / No Stroke Yes / No HIV Positive Yes / No HIV Positive Yes / No Shortness of Breath Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No Gonorrhea		Yes / No	Hemophi		Yes / No _	
Epilepsy Yes / No Back Injury Yes / No Back Injury Yes / No Back Pain Yes / No Back Pain Yes / No Stroke Yes / No HIV Positive Yes / No HIV Positive Yes / No AIDS Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No Message And Service Yes / No Gonorrhea Yes / No Message And Service Yes / No M	Sinus Trouble	Yes / No	Other Bl		Yes / No _	
High / Low Blood Sugar Yes / No Back Pain Yes / No Stroke Yes / No Swelling of Ankles Yes / No HIV Positive Yes / No Shortness of Breath Yes / No Syphilis, Herpes Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No	Epilepsy	Yes / No	Back Inj	ury	Yes / No _	
Thyroid Problems Yes / No Stroke Yes / No Swelling of Ankles Yes / No HIV Positive Yes / No Shortness of Breath Yes / No AIDS Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No Stroke Yes / No	High / Low Blood Sugar	Yes / No	Back Pai	n	Yes / No _	
Swelling of Ankles       Yes / No       HIV Positive       Yes / No         Shortness of Breath       Yes / No       AIDS       Yes / No         Faint Easily       Yes / No       Syphilis, Herpes       Yes / No         Steroid Therapy (Cortisone)       Yes / No       Gonorrhea       Yes / No	9	Yes / No	Stroke		Yes / No	
Shortness of Breath Yes / No AIDS Yes / No Faint Easily Yes / No Syphilis, Herpes Yes / No Gonorrhea Yes / No Yes		Yes / No	HIV Posi	itive	Yes / No	
Faint Easily Yes / No Syphilis, Herpes Yes / No Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No		Yes / No	AIDS		Yes / No	
Steroid Therapy (Cortisone) Yes / No Gonorrhea Yes / No		Yes / No	Synhilis.	Herpes	Yes / No	
Henstitis Ves / No	•	Yes / No	Symms, Gonorrh		Yes / No	
	Hepatitis	Ves / No				

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## **HEALTH HISTORY**

Are you allergic to Penicillin Any other medication allergies:	Codeine	Local Anesthetics	Demerol	Valium	Latex
Any other medication allergies: Are you pregnant? No	Yes If	yes, how many weeks/mo	nths?	·	
DENTAL HISTORY					
How important is your smile to	vou on a scale o	f 1 to 102 Tan	haina yany impa	wt (374 t	
		<del></del>			
Do you fear dental visits?					
Have you ever had any serious p					
Have you ever had excessive ble					
Have you ever been told you have					
Date of last "yearly" dental x-ra	ıys	Have you ever had Nitr	ous Oxide?		
Are you in pain today?	If yes, expla	in			
INSURANCE INFORMA	ATION				
Primary Insurance Carrier		Group #	Emp	loyer	
Name of Employee		E	mployees SS# _		
Employees Date of Birth		Relationship of	patient to employ	yee: self / sp	ouse / child
Who is the person responsible for	or payment on thi	s account?			
If you are a college student and a	are carried by yo	u parent's insurance, which	ı college do you	presently atter	nd?
		Full Time Pa	rt time		
As a courtesy to our patient insurance will pay, you are responsibility to understant request. It is your responsible **** Phone verif	e responsible jud the terms of ind continuous of indication of in	for any portion NOT of your insurance police	covered by yo cy. A Pre-Dete a waiting per is never a g	ur insurancermination stied.	e company. It is your will be sent upon your
insurance will pay, you are responsibility to understant request. It is your responsi	e responsible jud the terms of ind continuous of indication of in	for any portion NOT of your insurance policy out if your policy has a new manage coverage	covered by yo cy. A Pre-Dete a waiting per is never a g	ur insurancermination stied.	e company. It is your will be sent upon your
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insurance will pay, you are responsibility to understant request. It is your response **** Phone verif	e responsible jud the terms of ibility to find of in the fication of in PAYMENT IS	for any portion NOT of your insurance policy has bout if your policy has been surance coverage.  S REQUIRED WHEN SE  Data	covered by yo cy. A Pre-Dete a waiting per is never a g RVICES ARE	ur insurance ermination v iod. guarantee RENDERED	e company. It is your will be sent upon your
insurance will pay, you are responsibility to understant request. It is your response **** Phone verif  Signature  Medical History and Patient In	e responsible and the terms of ibility to find of the fication of in PAYMENT IS nformation Upday as needed (at le	for any portion NOT of your insurance policy has cout if your policy has an annual series of the ser	covered by yo by. A Pre-Dete a waiting per a gas is never a gas RVICES ARE	ur insurance ermination vi iod. guarantee RENDERED	e company. It is your will be sent upon your

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