Patient' Name: _____ DOB: _____

□ Parent/ □ Legal Guardian/ □ Responsible Adult (If patient under 18 year's old): _____

*Please answer all questions. Have you ever had or have:

	Yes	No		Yes	No		Yes	No
Allergies/ Hay fever			High Blood Pressure			Stroke		
Asthma			Low Blood Pressure			Fainting Spells/Seizures		
Tuberculosis			Heart Disease/Surgery			Neurological Disorders		
Respiratory disease			Heart Attack			Epilepsy		
Diabetes type 1 or 2			Pace Maker/Heart valve replaced			Joint Replacement (i.e. Hip or Knee)		
Anemia			Rheumatic Fever			Mental Health issues (i.e. Depression)		
Hepatitis/Jaundice			Gastrointestinal Problems			Autoimmune disease (I.e. Lupus)		
Liver disease			Glaucoma			Kidney Problems/Dialysis		
Cancer			Osteoporosis/Bisphosphonates			Birth Control Medication (women)		
Bleeding tendency			AIDS/HIV +			Sensitive Teeth		
Tooth pain			Bleeding Gums			Grinding Your Teeth		
Mouth ulcers/sores			Dry Mouth			Fear of Dental Treatment		
Past orthodontic tx.			Active in Sports/Other activities			Latex Allergy		

1. Are you pregnant? _____ Is the pregnancy confidential?_____ Due Date: _____

2. Do you have any disease, condition or problems not listed above? _____

3. Do you have any medication allergies? _____

Current Medication (s)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Name of Medical Doctor: _____ Telephone number: _____

In Case of emergency, contact person: _____ Telephone number: _____

To the best of my knowledge all medical information is correct and current.

X_____ _____

Signature (parent or guardian if patient is under 18 years old Date

For office use only

Review by Dr: _____ Signature: _____

Date: _____