MR.
MRS.
MISS

REGISTRATION DATE

DATE OF BIRTH

S M W D

HOME ADDRESS

HOME PHONE

CITY

ZIP

CELL PHONE

EMPLOYER

ADDRESS

SOC SEC NO.

OCCUPATION

WORK PHONE

PREVIOUS ADDRESS

CITY

STATE

PERSON RESPONSIBLE FOR ACCOUNT

ADDRESS

CITY

STATE

REFERRED BY

PHYSICIAN

DENTAL INSURANCE PROGRAM

LOCAL NO.

PURPOSE OF CALL

PREFERRED DAY FOR APPTS.

TIME

AM
PM

REMARKS

OVER →

MEDICAL HISTORY

1. Are you in good health? _____
2. Are you under a physicians care now? _____ if so, please give reason for treatment.

_____

3. Are you taking any kind of medication at this time? List: _____
4. Please circle any illnesses you have ever had:

allergies	tuberculosis	anemia	kidney or liver	High blood pressure
rheumatic fever	diabetes	heart trouble	asthma	____ Controlled
Infectious hepatitis	epilepsy	glaucoma	AIDS	____ Uncontrolled
				Other

5. Have you ever had trouble with prolonged bleeding after surgery? _____
6. Have you ever had any unusual reaction to anesthetic or drug (like penicillin)? _____
7. Is there any other information that should be known
   about your health? _____
   about your dental visits? _____
8. Have you ever been tested for HIV Virus? _____
   Result: _____
9. Chief Complaint: _____

X _____
Signature