PATIENT NUMBER

Name _____
(Last Name) (First Name) (Middle Initial)

Address _____

Social Security _____ Date of Birth _____ Home Phone _____

Employed By _____ Occupation _____ Bus. Phone _____

Spouse's Name _____ Occupation _____ Employer _____ Bus. Phone _____

Referred By _____ Insurance Co. _____

1. Physician's Name _____
   Address _____
2. Have you ever had a serious illness or operation? ..... Yes No
   If so, explain _____
3. Are you under a physician's care? ..... Yes No
   If so, explain _____
4. When was your last complete physical exam? _____
5. Are you taking any medication? ..... Yes No
   Please List
6. Are you allergic to any medications or substances? ..... Yes No
   Please List
   Do you have any problems with penicillin, antibiotics,
   anesthetics or other medications? ..... Yes No
7. Have you been treated for or been told you might
   have heart disease? ..... Yes No
   Do you have a pacemaker or an artificial heart valve implant? Yes No
8. Are you aware of any heart murmurs? ..... Yes No
9. Have you ever had rheumatic fever? ..... Yes No
10. Have you ever had surgery, radiation treatment, chemo
    treatment for a tumor, growth, or other conditions? ..... Yes No
11. Do you have high or low blood pressure? ..... Yes No
12. Do you have inflammatory diseases, such as arthritis
    or rheumatism? ..... Yes No
13. Do you have any artificial joints/prosthesis? ..... Yes No
14. Do you have any blood disorders, such as
    anemia, leukemia, etc.? ..... Yes No
15. Have you ever bled excessively after being cut or injured? .... Yes No
16. Do you have any stomach problems? ..... Yes No
17. Do you have any kidney problems? ..... Yes No
18. Do you have any liver problems? ..... Yes No
19. Are you diabetic? ..... Yes No
20. Do you have asthma? ..... Yes No
21. Do you have epilepsy or seizure disorders? ..... Yes No
22. Do you have or have you had venereal disease? ..... Yes No
23. Are you HIV positive? ..... Yes No
24. Have you ever had hepatitis? ..... Yes No
25. Do you or have you had T.B.? ..... Yes No
26. Do you smoke? ..... Yes No
27. Do you consume alcoholic beverages? ..... Yes No
28. Are you pregnant or suspect you may be? ..... Yes No
29. Do you have any disease, condition or problem
    not listed? If so, explain _____
30. Is there anything else we should know about your health
    that we have not covered in this form? _____
31. Would you like to speak to the Doctor privately
    about any problem? ..... Yes No

Medical Conditions/Medications

I certify that the above information is complete and accurate.

Patient's Signature _____ Date _____

Dentist's Signature _____ Date _____

ANEST.	MED. ALERT

MEDICAL HISTORY