	PATIENT NAME HOME ADDRESS E-MAIL EMPLOYER INSURANCE CO.					DATE OF HOME P CELL P BUSINESS P	BIRTH _ HONE _ HONE _ HONE _				PATIENT NAME	
11. 22. 33. 4. 55.	Are you under medical treatment now? Have you ever been hospitalized for any surgical operation or serious illness? Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? Have you ever taken Fen-Phen/Redux? Do you use tobacco? Do you use alcohol, cocaine or other drugs?	YES	HONE NO O O O O O O O O O O O O O O O O O	8. A Y I I 9. W	re you ES NO L (C VOMEN a) Are b) Are	allergic to or have ocal anesthetics eg. novocaine) Penicillin or other antibiotics oulfa Drugs ONLY: Period pregnant of the property of the p	re you had YES NO S S S Think you control pi	d any reaction Barbiturates Bedatives odine I may be prequils? throat clearing	ns to the follows to the follows NO	owing? irin er S NO Ciated		
11.	Heart Attack Card Rheumatic Fever Heart Swollen Ankles Angir Fainting / Seizures Angir Asthma Anen Low/High Blood Pressure Empt Epilepsy / Convulsions Cand Leukemia Arthri Diabetes Diabetes Kidney Diseases Hepc	Disease iac Pacem Murmur na uently Tired nia nysema	nent o dice itted l	or Implc Disease	YES	NO Chest Pains Easily Winde Stroke Hay Fever / Tuberculosis Radiation Th Glaucoma Recent Wei Liver Disease Mitral Valve Respiratory Other	Allergies enerapy ght Loss e Prolapse	COMMEN Signature of De	ITS		Date	
3 2 5	 Do your gums bleed while brushing or flossing. Are your teeth sensitive to hot or cold liquid. Are your teeth sensitive to sweet or sour liquid. Do you feel pain to any of your teeth? Do you have any sores or lumps in or near your had any head, neck or jaw injuries. Have you ever experienced any of the follow problems in your jaw? Clicking? Pain (joint, ear, side of face)? Difficulty in opening or closing and) Difficulty in chewing? 	ng? s/foods? ids/foods? our mouth es? wing	YES		1 1 1	8. Do you have 9. Do you clenc 0. Do you bite y 1. Have you ever in the past? 2. Have you had 3. Have you ever following extre 4. Have you ever correct metho 5. Have you ever care of your g	h or grind our lips or er had any orthor actions? er had instructed of brus er had instructed or brus er had en	your teeth? cheeks freque difficult extro odontic treatr longed bleed ruction on the hing your teet	ment? ding th?	YES		
S	I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. SIGNATURE X											

PATIENT, PARENT OR GUARDIAN

DATE