PERSONAL INFORMATION DATE: _____

Name: _____

Address: _____ City: _____ Postal: _____

Home phone #: _____ Work phone #: _____

Employer/Occupation: _____ Birthdate: _____

Referred By: _____ Physician's Name: _____

DENTAL INSURANCE INFORMATION: Please Note: It is the patient's responsibility to provide complete and current dental insurance information.

Name of Ins. Carrier: _____ Name of Ins. Carrier: _____

Group #: _____ Div. #: _____ Group #: _____ Div #: _____

Cert/ID#: _____ Dep.#: _____ Cert/ID#: _____ Dep.#: _____

Basic ____% Major ____% Ortho ____% Basic ____% Major ____% Ortho ____%

Maximum per Year Deductible Maximum Deductible

MEDICAL HISTORY: CIRCLE ONE

1) Have you ever had a serious illness or are you under the care of a physician now? YES NO
2) Have you had a medical examination in the last year? YES NO
3) Do you use any medicine/drugs regularly YES NO
4) Have you ever had the following diseases: (Check all that apply)
   Jaundice_____ Epilepsy_____ Cancer_____ Tuberculosis_____ Kidney disease_____
   Diabetes_____ Arthritis_____ Stroke_____ Lung disease_____ Thyroid disease_____
   Hepatitis_____ High Blood Pressure_____ Heart Attack_____ Heart disease_____
   Rheumatic fever_____ Gastrointestinal disease_____ Venereal disease _____
   Mental or Nervous disease _____
5) Have you ever tested positive for HIV or AIDS? YES NO
6) Do you ever have asthma, hay fever, hives or skin rashes? YES NO
7) Have you experienced any unusual reaction to local anaesthetic (freezing)? YES NO
8) Have you ever had any unusual reaction to the following drugs: (Check all that apply)
   Aspirin____Iodine____Barbiturates____Sulfa drugs____Penicillin____Other____
9) Do you bruise easily or bleed abnormally? YES NO
10) Have you ever had surgery or X-Ray therapy on your face or jaws? YES NO
11) Is there a history of family disease? if so, what? _____ YES NO
12) WOMEN ONLY- Are you pregnant? if so, what month? _____ YES NO

DENTAL HISTORY:

What dental condition concerns you at present? _____
Have you had a regular dental examination in the past? (Annually or Semi-annually) YES NO
Do you brush your teeth daily? YES NO
Do you use dental floss daily? YES NO
Have you been instructed on the correct method of brushing and flossing? YES NO
Have you had any teeth extracted due to: (check all that apply)
accident____decay____gum disease____other_____
Do you have any oral habits such as: Clenching___Grinding___ Nail biting____
Have you had: Fixed bridges____ complete dentures____partial dentures____ crowns____
Have you ever had: Root canal treatment___ Periodontal (gum) treatment____
Abscessed tooth/teeth___ Sore mouth____

_____ _____

PATIENT'S SIGNATURE DATE