Patient's Name: _____ **Referring Dentist:** _____

Nickname: _____ **Birth Date:** _____ **Soc. Sec. No.:** _____

1. Are you having any pain or discomfort at this time? ☐ Yes ☐ No
2. Do you feel **very** nervous about having dental treatment? ☐ Yes ☐ No
3. Have you ever had a bad experience in a dental office before? ☐ Yes ☐ No
4. Are you under the care of a physician for a current problem? ☐ Yes ☐ No
   Physician: _____ Phone: _____
5. Are you taking any prescription, or non-prescription, medications or drugs? ☐ Yes ☐ No
   Please specify: _____
   _____
6. Have you ever been tested for HIV infection (AIDS)? ☐ Yes ☐ No
   Date: _____ ☐ POSITVE ☐ NEGATIVE
7. Have you ever taken Fen-Phen? ☐ Yes ☐ No
8. Please specify any ALLERGIES OR ADVERSE REACTIONS you have ever had to local anesthetics, latex, antibiotics, aspirin, or any other medications: _____
   _____
9. Please place a mark on "Yes" or "No" to indicate if you have had, or currently have, any of the following:

High Blood Pressure	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Mitral Valve Prolapse (MVP)	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Joint Prosthesis (hip, knee, etc.)	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No Type ____
Prosthetic Heart Valve	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	TMJ or TMD	☐ Yes ☐ No

10. Have you had any other disease, condition or problem not listed above? _____
    _____
11. Are you required to take any antibiotics prior to all dental treatment? ☐ Yes ☐ No

FOR WOMEN ONLY:

Are you pregnant now? ☐ Yes ☐ No Estimated Delivery Date: _____
Do you anticipate becoming pregnant soon? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you using birth control medication? ☐ Yes ☐ No

Antibiotics (such as penicillin) may alter the effectiveness of birth control medication. Please consult your physician for recommendations regarding alternative methods of birth control, if taking antibiotics.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient's Signature: _____ Date: _____

For Office Use

Blood Pressure: _____ Pulse: _____

Doctor's Signature: _____ Date: _____