| PERSONAL INFORM |
|-----------------|
|-----------------|

Date

This personal information will help us to give you the most consideration of your time and feelings. It is important to have complete answers. All information is, of course, confidential.

| Vame  |  |  | Spouse or pare   | nt               |     |  |
|---|--|--|--|------------------|-----|--|
| Address   |  |  | Address  |                  |     |  |
| Dity  | State  | Zip  | City   | State Zip        | )   |  |
| Birthdate   | SS#  |  |  | Birthdațe SS#    |     |  |
| Driver License #  | er License #   |  | Employer   | Оссир.           |     |  |
| Home Phone  | Bus  | iness Phone  | Dental Ins.  | Yes              | No_ |  |
| Employer  | Occ  | cup.   | Insurance Co. N  | lame (primary)   |     |  |
| f Student, name of  | school:  |  | Address  |                  |     |  |
|   | ther   |  | City   | State Z          | ip  |  |
| Mother  | or C   | Guardian   | Employee's nar   | ne               |     |  |
| Are you aware of a  | ou aware of any particular dental problems?  |  | Employee's SS  | #                |     |  |
|   |  |  | Insurance Co. N  | lame (secondary) |     |  |
| Are you having any  | y discomfort or pain?  |  | Address  |                  |     |  |
| How long has it be  | een since you last visited   | d a dental office?   | City   | State            | Zip |  |
|   | r you at that time?  |  | Employer   |                  |     |  |
|   | ecommended this office   | ?  | Employee's Na  |                  |     |  |
|   |  |  | Employee's SS  | #                |     |  |
| Jnder a physician'<br>Have you had any<br>What tablets, pills | form of Cancer? Yes  | No No  | If so, for what?  If so, what type or nar tamins, birth contro |                  | )   |  |
| Does your physicial for so, what?                             | an require you to take sp  | pecial medication be   | efore dentistry?   | Yes              | No  |  |
| Date  |  | UP-DATES O   | N PERSONAL INFORMAT  | 10N              |     |  |
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## HEALTH HISTORY (CON'T.)

| DO YOU HAVE OR HAVE YOU HAD A  | YES NO   | YES NO  |
|--|--|---|
| Rheumatic fever, rheumatic heart diseas  | e Radiation treatment                                      |   |
| Heart trouble, heart attack, high blood  | Sores that did not heal within one week                    |   |
| pressure, stroke   | Women: Are you pregnant?                                   |   |
| Heart murmur, Mitral Valve Prolapse  | Post menopause?  |   |
| Pain in chest, shortmess of breath,  | Do you smoke?  |   |
| swollen ankles   | Do you consistently use:                                   |   |
| Blood disorders, anemia  | Tobacco  |   |
| Cold sores or herpes incident.   | Drugs  |   |
| Positive test for aids virus (HIV)   | Alcohol  |   |
| Abnormal bleeding, prolonged healing.  | Are you sensitive or allergic to:                          |   |
| bruise easily, blood transfusion   | Penicillin   |   |
| Asthma, hay fever  | Codeine  |   |
| Low blood pressure   | Anesthetic   |   |
| Fainting spells, seizures  | Aspirin  | 2 100 C 100 |
| Hepatitis, jaundice, liver diseases  | Latex  |   |
| Arthritis  | Other drugs  |   |
| Have you had an orthopedic   |  |   |
| joint replacement  | Do you have any disease, condition or problem              | not listed  |
| and the same of th | above that you think the doctor should know abo            |   |
| Have you had an organ transplant   | above that you think the doctor should know abo            | · · · · · · · · · · · · · · · · · · ·   |
| Pacemaker  |  |   |
| Kidney troubles  |  |   |
| Tuberculosis, other lung ailments  |  |   |
| Persistent œugh, çough up blood  |  |   |
| Diabetes   |  |   |
| practitioners. I authorize and request my i  Date Signature of Patient or  | nsurance company to pay directly to the dentist.  Guardian |   |
| Information Reviewed:  |  |   |
| Date   | Signature of Patient or Guardian                           |   |
| Information Reviewed:  |  |   |
| Date   | Signature of Patient or Guardian                           |   |
| Information Reviewed:  |  |   |
| Date   | Signature of Patient or Guardian                           |   |
| Information Reviewed:  | Signature of Patient or Guardian                           |   |
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| Date Doctor's Notes and Update:  |  |   |
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