

Patient Information and Health History

Name _____ DOB _____ Age _____ Social Security# _____

Home Address _____ City _____ Zipcode _____ Phone Number _____

Referred to Dr. White by _____

Financially Responsible _____ Relationship to you _____ Social Security # _____

Your Occupation _____ Employer _____ Phone Number _____

Spouse Name (if applicable) _____ DOB _____ Employer _____ Social Security# _____

Dental Insurance _____ Group or Plan # _____

Person to contact in case of Emergency _____ Phone Number _____

Physician _____ Address _____ Phone Number _____

Are you in good health? _____ If no, please explain _____

Have you been hospitalized in the past two years? _____ If yes, please explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

List all medications or drugs you are taking _____

Do you now have, or have you had any of the following? (If yes, please describe under remarks)

- | | YES | NO | | YES | NO |
|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | 15. Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | 16. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | 17. Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | 18. Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | 19. AIDS or HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | 20. Other Sexually Transmitted Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | 21. Allergy to: Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Tumor History | <input type="checkbox"/> | <input type="checkbox"/> | 22. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 13. Artificial Joints | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Remarks or any other medical conditions not listed above _____

Do you have any present dental complaints? _____

When was your last full mouth x-ray taken? _____ When was your last cleaning? _____

I have thoroughly completed this form and have not excluded any important medication information. I also agree to assume full financial responsibility for all treatment rendered.

Signature _____ Date _____