First Name: ________________ MI: ________ Last: ________________

Social Security Number: ________________ Address: ________________

City: ________________ State: ________ Zip Code: ________________

Date of birth: ________________ Email: ________________

Home Number: ________________ Cell Number: ________________

Best number to reach you at: HOME/CELL How did you hear about us? ________________

Medical & Dental History

Are you currently under a physician's care? □ Yes □ No

If Yes, please explain in detail: ________________

____

Physician's Name: ________________ Phone Number: ________________

Has a Physician or Dentist ever recommended you to take antibiotics before dental treatment? □Yes □No

Have you ever had or do you currently have any of the following conditions?

	Yes	No		Yes	No
Bleeding Problems	□	□	High blood Pressure	□	□
Heart Murmur	□	□	Stroke	□	□
Breathing Problems	□	□	HIV/ AIDS	□	□
Cancer	□	□	Joint Replacement	□	□
Diabetes	□	□	Organ Transplant	□	□
Heart Disease	□	□	Snoring/ Sleep Apnea	□	□
Hepatitis	□	□	Taking Blood Thinners	□	□

List all current medications: ________________

Are you allergic or have you had a bad reaction to any of the following?

□ Latex □ Antibiotics ________________ □ Other Drugs ________________

Female Patients:

Are you pregnant? □ Yes □ No **Trimester:** 1st 2nd 3rd **Are you nursing?** □Yes □ No

Name of OB/ GYN: ________________ Phone Number: ________________