

Name _____ Address _____

City _____ State _____ Zip _____ Sex (M/F) _____

Home Phone _____ Work Phone _____ Cell _____

Marital Status _____ Birthdate _____ Social Security # _____

Name Of Responsible Party _____ Billing Address _____

Employer _____ Insurance _____

Referred By _____ E-Mail Address _____

Yes	No	Does Your Medical History Include Any Of The Following:
_____	_____	Allergies to Anesthetics
_____	_____	Allergies to any Medications
_____	_____	Any Heart Ailments/Heart Murmur
_____	_____	Rheumatic Fever
_____	_____	High Or Low Blood Pressure
_____	_____	Neurological Disorders
_____	_____	Radiation Treatment
_____	_____	Excessive Bleeding From Cut Or Extraction
_____	_____	Anemia Or Blood Problems
_____	_____	Arthritis
_____	_____	Asthma
_____	_____	Hay Fever Or Allergies In General
_____	_____	Diabetes /Kidney Problems
_____	_____	Liver Problems or Hepatitis
_____	_____	Malignancies
_____	_____	Psychiatric Care
_____	_____	Sinus Problems
_____	_____	Stroke
_____	_____	Thyroid
_____	_____	Eye Disorder
_____	_____	Tonsillitis
_____	_____	Tuberculosis
_____	_____	Ulcer Or Colitis
_____	_____	Pregnancy- If So What Month _____
_____	_____	Venereal Disease
_____	_____	Acquired Immune Deficiency Syndrome (AIDS)
_____	_____	Any Other Medical Conditions _____

List Any Drugs or Medications You are Currently Taking _____

In Case Of Emergency, Notify _____ Phone # _____

Patient Signature _____ Date _____