PERSONAL INFORMATION

Name: ____ Date: ______________________________
Street address: ____
City: ________________________ State: _________________ Zip: ___________________
Home phone: __________________ Business phone: _____________ Cell phone:_____________
Birth date: _____________________ Sex: _______ Height: _______ Weight: _______ Age: _______
Place of employment: ____________________________ Occupation: ______________________________
Social security number: __________________________ Email address: ___________________________
Marital Status: _________________________________ Emergency contact:________________________
Phone number: _____________________________ Relationship: _____________________________

DENTAL INSURANCE INFORMATION

Company: __________________ Subscriber name: _______________ Subscriber birth date: _________
ID#: _______________________

HEALTH INFORMATION

1. Are you in good health? ____

2. Are you now under the care of a physician? ____
   If yes, for what reason? ____

3. Have you been hospitalized or seriously ill within the past five years? __________________________
   If yes, for what reason? ____

4. Please circle any of the following health conditions that pertain to you:

high blood pressure	heart disease	heart murmur	lung disease
asthma	epilepsy	diabetes	joint replacement
hepatitis/liver disease	glaucoma	cancer	heart valve
arthritis	blood disorders	osteoporosis	renal disease

5. Do you have any disease or health condition that we should know about? ________________________
   ____

6. Please list any drugs or medications you are taking at this time: ______________________________
   ____

7. Are you taking blood thinners or aspirin? ____

8. Are you taking any drugs for bone density or osteoporosis (i.e. Fosamax or Actonel?)_______________

9. Are you taking Viagra (sildenafil citrate) or drugs of this type?____________________________

10. Please list any allergies you have: ____

11. Do you smoke or use tobacco products? ____

WOMEN

12. Are you pregnant? ____

13. Are you taking oral contraceptives or hormonal therapy? __________________________________