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: ____________________