WELCOME BACK

Patient's name: _____ DOB: _____

Guardian's name: _____

Change of address? Yes____ No____
If yes, please update _____

Please update the following phone numbers:
Home # _____
Cell # _____
Work # _____
Emergency # _____ Person to Contact: _____

Please update e-mail address: _____@_____

Are you under medical treatment now? Yes____ No____
If yes, please explain _____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs? Yes____ No____
If yes, please explain _____

Are you taking any medication(s) including non-prescription medicine? Yes____ No____
If yes, please explain _____

Have you ever taken Fen-Phen / Redux? Yes____ No____

Do you use Tobacco? Yes____ No____ Controlled substances? Yes____ No____

Do you have any allergic reactions? _____

Do you have persistent cough not associated with a known illness? Yes____ No____

Do you need to be pre-medicated before dental procedures due to medical conditions? Yes____ No____
If yes, please describe _____

Women only: Are you pregnant? Yes____ No____ Nursing? Yes____ No____ Taking contraceptives? Yes____ No____

Do you have or had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	□	□	Heart Disease	□	□	Chest Pains	□	□
Heart Attack	□	□	Cardiac Pacemaker	□	□	Easily Winded	□	□
Rheumatic Fever	□	□	Heart Murmur	□	□	Stroke	□	□
Swollen Ankles	□	□	Angina	□	□	Hay Fever Allergies	□	□
Fainting / Seizures	□	□	Frequently Tired	□	□	Tuberculosis	□	□
Asthma	□	□	Anemia	□	□	Radiation Therapy	□	□
Low Blood Pressure	□	□	Emphysema	□	□	Glaucoma	□	□
Epilepsy / Convulsions	□	□	Cancer	□	□	Recent Weight Loss	□	□
Leukemia	□	□	Arthritis	□	□	Liver Disease	□	□
Diabetes	□	□	Joint Replacement or Implant	□	□	Heart Trouble	□	□
Kidney Diseases	□	□	Hepatitis / Jaundice	□	□	Respiratory Problems	□	□
AIDS or HIV Infection	□	□	Sexually Transmitted Disease	□	□	Mitral Valve Prolapse	□	□
Thyroid Problem	□	□	Stomach Troubles / Ulcers	□	□	Psychiatric Problems	□	□

AUTHORIZATION AND RELEASE
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and / or health practitioners. I authorize and request my insurance to pay directly to the dentist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual services rendered on my behalf or my dependents.

1st visit – Signature of patient (parent or guardian if minor) _____ Date _____

Doctor's Signature _____ Date _____

2nd visit – Signature of patient (parent or guardian if minor) _____ Date _____

Doctor's Signature_____ Date _____ Changes? Yes____ No____