Date_____

Name: _____ Date of Birth: _____

Home Address _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

☐ M ☐ F

Social Security # _____

Business: _____ Bus. Phone: _____

Address: _____

Referred by Dr.: _____ Telephone: _____

Address: _____

Physician: _____ Telephone: _____

PLEASE CHECK OFF ANY CURRENT OR PAST CONDITION

MEDICAL HISTORY

- ☐ Rheumatic Fever
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Presently Pregnant
- ☐ Swollen Glands
- ☐ Joint Replacement
- ☐ Diabetes
- ☐ Nephritis
- ☐ Hepatitis
- ☐ T.B.
- ☐ Immune System Disorders (Aids, HIV, ARC)
- ☐ Osteopenia/ Osteoporosis
- ☐ Other_____

ALLERGIES

- ☐ Local Anesthesia
- ☐ Latex
- ☐ Penicillin
- ☐ Other Drugs _____

MEDICATIONS CURRENTLY BEING TAKEN

- ☐ Antibiotics
- ☐ Corticosteroid
- ☐ Other _____

CONDITION OF TOOTH:

PAST:	☐ Intense Pain	☐ Moderate Pain	☐ No Pain	
PRESENT:	☐ Intense Pain	☐ Moderate Pain	☐ No Pain	

SUBJECTIVE SYMPTOMS:

TYPE OF PAIN:	☐ Sharp	☐ Localized	**CAUSED BY:**	☐ Heat	☐ Pressure
	☐ Dull	☐ Diffuse		☐ Cold	☐ Spontaneous
	☐ Throbbing			☐ Sweet	

Signature:_____

(Patient or in case of minor, responsible party)