PERSONAL HISTORY

*DATE:*____________________

*PATIENT'S NAME:*____

(IF A MINOR OR DEPENDENT) PARENT/GUARDIAN'S NAME: ________________________

STREET ADDRESS: ____________________ *CITY:* __________ *STATE:* _____ *ZIP:* __________

HOME PHONE: _________________ *CELL PHONE:* ______________

EMAIL ADDRESS: ________________________ *WHO REFERRED YOU TO OUR OFFICE?* _________

DENTAL INSURANCE ☐ *YES* ☐ *NO* *IF SO, WHICH ONE:* ____________________________

DO YOU HAVE OR HAVE YOU HAD?	YES	NO	EXPLANATION
ALLERGIES TO DRUGS			
ALLERGIES TO LATEX			
ALZHEIMERS			
ARTIFICIAL HEART VALVE			
ARTIFICIAL JOINTS			
BLOOD THINNER			
CANCER			
CHEMOTHERAPY			
CLOTTING PROBLEMS			
DIABETES			
DRY MOUTH			
HEART DISEASE			
HEPATITIS			
HIGH BLOOD PRESSURE			
HIV/ AIDS			
LIVER DISEASE			
MITRAL VALVE PROLAPSE			
MOUTH SORES			
OSTEOPOROSIS			
PARKINSONS			
RADIATION THERAPY			
RECENT MAJOR SURGERY			
RESPIRATORY CONDITIONS			
RHEUMATIC FEVER			
THYROID PROBLEMS			
BLEEDING GUMS			
TOOTH SENSITIVITY			
PREVIOUS GUM TREATMENT			WHEN:
OTHER			

Emergency Contact

*Name:*________________________

*Phone:*________________________

*Relationship:*____________________

Preferred Pharmacy:

Name: ________________________

Phone: ________________________

Physician Contact

Name: ________________________

Phone: ________________________

Specialty: ______________________

PLEASE LIST ALL THE MEDICATIONS YOU ARE NOW TAKING:

____

____

____

____

____

____

DO YOU SMOKE? YES _____ NO _____
HOW LONG _________
HOW MUCH? ___PACKS ____CIGARETTES/DAY

HOW OFTEN DO YOU BRUSH YOUR TEETH?____________________
DO YOU FLOSS? YES _____ NO _____

WOMEN ONLY:
ARE YOU: PREGNANT/ BREASTFEEDING
YES _____ NO _____