Health Information

Have you ever had any of the following? Please check those that apply:		
☐ AIDS	☐ Growths	☐ Radiation Treatment
☐ Allergies ___________	☐ Hay Fever	☐ Respiratory Problems
☐ Anemia	☐ Head Injuries	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Disease	☐ Rheumatism
☐ Artificial Joints	☐ Heart Mur Mur	☐ Sinus Problems
☐ Asthma	☐ Hepatitis	☐ Stomach Problems
☐ Blood Disease	☐ High Blood Pressure	☐ Stroke
☐ Cancer	☐ Jaundice	☐ Tuberculosis
☐ Diabetes	☐ Kidney Disease	☐ Tumors

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No. If yes, please explain:____
- Are you now under the care of a physician? Yes No. If yes, please explain: ________________ ____
- Name of Physician:__________________________________Phone:______________________
- Do you have any health problems that need further clarification? Yes No. If yes, please explain: ____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: _______________________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend___ Relative___

Dental Office___ Yellow Pages___ School___ Work___ Other_____________________________

Name of person or office referring you to our practice: __________________________________