High/Low Blood Pressure ☐ Psychiatric care ☐ Sinus ☐ Stroke ☐ Special Diet ☐
any other major illnesses_____

Yes No Do you bleed easily?
Yes No Is there a tendency to faint or become dizzy?
Yes No Do you have allergies? (sulfa, penicillin, novacaine, latex, etc.)? _____
Yes No Are you currently taking any medications? List _____
Yes No Do you have a heart condition, hip or knee replacement?
Yes No Do you have to pre-medicate? Cardiologist _____
Yes No Do you have sleep apnea?
Yes No Do you smoke or chew tobacco?
Yes No Have there been any injuries to your teeth? Explain_____
Yes No Have you had any permanent/adult teeth extracted?
Yes No Have we treated any other family member? If so, who?_____

WOMEN

Are you pregnant? _____ Due date_____ Are you nursing? _____

I understand that I am financially responsible for all charges regardless of my insurance coverage. Payment is due the day services are rendered.

Signature_____ **Date**_____

STOP

Updates (**To be filled in at future appointments**-the law requires this information be updated every 5 years)

Have there been any changes in your health since your last visit with us? Yes ☐ No ☐
If Yes, for what conditions? _____
Are you taking new medications? Yes ☐ No ☐ If so, what? _____

Patient's Signature _____ Date _____
Doctor's Signature _____ Date_____

Updates (**To be filled in at future appointments**-the law requires this information be updated every 5 years)

Have there been any changes in your health since your last visit with us? Yes ☐ No ☐
If Yes, for what conditions? _____
Are you taking new medications? Yes ☐ No ☐ If so, what? _____

Patient's Signature _____ Date _____
Doctor's Signature _____ Date_____