Name ____________ D.O.B. ____________ Marital Status ____________

Address ____________ Res. Phone ____________ Cell Phone ____________

____________ Occupation ____________

Soc. Sec. No. ____________ Employer ____________ Phone ____________

Insurance Coverage Yes____ No____ If yes, type____________

Physician ____________ Date of last physical ____________ Referred by ____________

Email address ____________

Dental History

	Please Circle	
Do you have a specific dental problem? Describe ____________	Yes	No
Do you have dental examinations on a routine basis? Last visit ____________	Yes	No
Do you brush and floss on a routine basis? Discuss ____________	Yes	No
Do your gums ever bleed? Discuss ____________	Yes	No
Do you like your smile? ____________	Yes	No
Would you like whiter teeth? ____________	Yes	No
Does food catch between your teeth? Any loose teeth? ____________	Yes	No
Do you want to keep your remaining teeth? ____________	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ____________	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Discuss ____________	Yes	No
Date of last full mouth x-rays (16 small films or panoramic): ____________		

Medical History

Are you under a physician's care now? Why? ____________	Yes	No
Have you ever been hospitalized or had a major operation? Discuss ____________	Yes	No
Have you ever had a serious injury to your head or neck? Discuss ____________	Yes	No
Are you taking any medications, pills or drugs? What? ____________	Yes	No
Are you on a special diet? Discuss ____________	Yes	No
Are you allergic to any medications or substances? Please check box below	Yes	No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other ____________		
WOMEN (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss ____________	Yes	No
Have you ever taken Bisphosponates (eg. Zometa, Aredia, Fosamax, etc. ____________	**Yes**	**No**

Do you now have or have you ever had any of the following? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur *	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐	Artificial Joint *	☐	☐	Nervousness	☐	☐
Heart Pace Maker *	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery *	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	Genital Herpes	☐	☐	Allergies (Pollen/Dust)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐	Drug Addiction	☐	☐	Hives or Rash	☐	☐

Have you ever had any other serious illness not checked above? Discuss ____________	Yes	No
Do you wish to talk to the dentist privately about any problem? ____________	Yes	No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ____________ Date ____________

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor ____________ Date ____________ BP ____________

History Review and Significant Findings: ____________

I grant Dr. Alan M. Kasperowski or Dr. Bryan M. Kasperowski permission to administer necessary anesthetics and medications and to employ procedures necessary for the diagnosis and treatment of my oral cavity.

____________ Patient

____________ Parent or Guardian