Hartland Gentle Dental

Name: _____SS#_____D.O.B_____

Cell Phone: _____ Home Phone: _____

Home address: _____

Email address _____

Ins Plan Name_____Subscriber_____ID#_____D.O.B._____

Secondary_____ Subscriber_____ ID#_____D.O.B_____

1. Are you currently under a physician's care? YES / NO
   If yes, what are you being treated for? _____
   _____
2. Have you recently had a serious illness, hospitalization, surgery or other general health problems?_____
3. Are you currently taking any medication? YES / NO
   If yes, please list those medications:
   _____
4. Are you required to pre-medicate for dental appointments: Y / N
5. Women: Are you pregnant? Y / N
6. Do you smoke? Y / N

   Have you ever had any of the following?

Rheumatic fever	Y / N	Fainting spells, seizure, epilepsy	Y / N
High blood pressure	Y / N	Hepatitis, jaundice, liver disease	Y / N
Heart trouble (mitral value) Heart disease, murmur	Y / N	Arthritic condition	Y / N
		Orthopedic joint replacement	Y / N
Pacemaker	Y / N	Organ transplant	Y / N
Blood disorder, anemia, transfusion	Y / N	Kidney troubles, dialysis	Y / N
Cold sores or herpes incident	Y / N	Tuberculosis, other lung ailments	Y / N
Use of tobacco/chewing tobacco	Y / N	Thyroid problems	Y / N
AIDS, ARC or HIV positive test	Y / N	Glaucoma	Y / N
Abnormal bleeding, bruising	Y / N	Radiation for tumor or growth	Y / N
Diabetes (blood sugar)	Y / N	Asthma, hay fever, hives	Y / N
Ulcers or intestinal problem	Y / N		

7. Are you allergic or sensitive to:

Penicillin	Y / N	Iodine	Y / N
Erythromycin	Y / N	Codeine	Y / N
Latex	Y / N	Local Anesthetics (Novocain)	Y / N
Aspirin	Y / N	Sulfa	Y / N

   Other (Please list):
   _____

Patient/Guardian Signature: _____ Date: _____