Center Square Family Dental
Lynn R. Walker DDS, MAGD
James D. Alcorn DMD

PATIENT | **DOB**

Home Address

Phones

SSN or ARN | Email

Occupation | Employer

SPOUSE

Name | DOB

Phones

Occup'n | Employer

Emergency Contact

Dental Insurance

DENTAL HISTORY

Current Dental Pain (Circle One) None Some Extreme

Location of pain?

When did the pain start?

Have you ever had a severe reaction to a dental treatment? No Yes

If yes, please explain here

Last dental visit?

Have you ever had gum disease? No Yes

MEDICAL HISTORY

Are you in good health? No Yes If no, please explain here

Do you have any existing illnesses? No Yes If yes, please explain here

Have you been hospitalized in the last two years? No Yes If yes, please explain here

Do you bleed excessively? No Yes

Do you smoke? No Yes If so, how much?

If you are taking any medications or drugs, please list the NAMES, DOSAGES and the REASONS for taking them in the box to the right:

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

Heart (Surgery, Disease, Other)	Yes	No	Radiation Treatment	Yes	No	Epilepsy or Seizures	Yes	No
High Blood Pressure	Yes	No	Chemotherapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Stroke	Yes	No	Venereal Disease	Yes	No	Nervousness/Anxiety	Yes	No
Chest Pain	Yes	No	Kidney Disease	Yes	No	Psychiatric/Psychological Care	Yes	No
Artificial Heart Valve	Yes	No	Cortisone Medication	Yes	No	Asthma	Yes	No
Heart Pacemaker	Yes	No	Artificial Joints (Hip/Knee/Other)	Yes	No	Tuberculosis	Yes	No
Mitral Valve Prolapse	Yes	No	Ulcers	Yes	No	Glaucoma	Yes	No
Swollen Ankles	Yes	No	Thyroid Problems	Yes	No	Hepatitis (If yes, put type ____)	Yes	No
Blood Disease	Yes	No	Hay Fever	Yes	No	Pregnant (If yes, due _____)	Yes	No
Rheumatic Fever	Yes	No	Sinus Trouble	Yes	No	Sickle Cell Disease	Yes	No
Heart Murmur	Yes	No	Diabetes	Yes	No	Cold Sores / Fever Blisters	Yes	No
HIV Positive	Yes	No	Hemophilia	Yes	No	Bruise Easily / On Blood Thinners	Yes	No
A.I.D.S.	Yes	No	Arthritis / Rheumatism	Yes	No	Liver Disease	Yes	No
Tumor History	Yes	No	Yellow Jaundice	Yes	No	Other Notable Disease / Condition	Yes	No

Please explain any other disease/condition not listed above_____

Please list ALL allergies (Penicillin, Other Antibiotics, Metals, Latex, Peanuts, etc.)

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT AND CONSENT TO PROCEED: I hereby certify that the answers to the health questions provided above are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of notifying the dentist of any changes to the information provided above and agree to provide such notice.

SIGNATURE _____ DATE _____

Patient, legal guardian, or authorized agent of patient