Date ____________________________

Louisville Dental Specialists

Patient Name ____ Address ____
Last First Middle

City _________________________ State _________ Zip Code __________ Home Phone ________________ Bus. Phone _____________

Cell Phone _________________ E-mail Address _________________________ Date of Birth ____________Age ______ Sex__________

Marital Status________ if minor, parent/guardian name____ Patient SS#_________________________

Patient/Parent/Guardian/Employer ____ Occupation _________________________________

Employer's Address ____Employer Phone_________________ Cell Phone_________________

Spouse/Parent Employer ____Bus. Phone ______________

Name & Address of person responsible for acct./ Insurance ____

Home phone ____________________ Bus. Phone __________________ SS# __________________ Date of Birth __________________

Employer ___________________________ E-mail address ___________________________ Cell Phone ___________________________

Name of closest relative not living in same household _____________________________________ Relation to Patient___________________

Address ____ Home Phone_____________________ Cell Phone_____________________

Referred by ____

Have you or other members of your family been a patient in our office before? _________ Name _____________________________________

Dental Insurance Co. ____________________________________ Policy # ____________Subscriber _____________ Phone _____________

Medical Insurance Co.___________________________________ Policy # ____________Subscriber _____________ Phone _____________

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. The name of my physician is ____Phone #_________________________

   The name of my dentist is ____Phone #________________________
2. Has there been any change in your general health within the past year? .... Yes No
3. My last physical examination was on ____
4. Are you now under the care of a physician?... Yes No
5. Have you had any serious illness or operation? .... Yes No
6. Do you have or have you had any of the following diseases or problems?

a.	Heart trouble..	Yes	No	**l.**	Kidney trouble..	Yes	No
b.	Heart murmur	Yes	No	**m.**	Tuberculosis...	Yes	No
c.	Rheumatic fever..	Yes	No	**n.**	Emphysema..	Yes	No
d.	High or low blood pressure..	Yes	No	**o.**	Sexually transmitted diseases	Yes	No
e.	Stroke...	Yes	No	**p.**	Epilepsy or seizures...............................	Yes	No
f.	Asthma...	Yes	No	**q.**	Psychiatric problems	Yes	No
g.	Diabetes..	Yes	No	**r.**	Cancer..	Yes	No
h.	Hepatitis, jaundice or liver disease	Yes	No	**s.**	HIV/AIDS	Yes	No
i.	Arthritis...	Yes	No	**t.**	Thyroid condition	Yes	No
j.	Stomach ulcers..	Yes	No	**u.**	Glaucoma...	Yes	No
k.	Joint replacement..	Yes	No	**v.**	Temporomandibular (TMJ) joint	Yes	No

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? .... Yes No
8. Do you have any blood disorder such as anemia? .... Yes No
9. Have you ever had radiation therapy for a tumor of the head or neck?.. Yes No
10. Are you taking any drugs or medicine? .... Yes No
11. Do you have a past or present history of illegal drugs or substance abuse?... Yes No
12. Are you allergic to any drugs or medicine?... Yes No
13. Do you have any disease, condition, or problem not listed above that you think we should know about?.............................. Yes No
14. Are you wearing contact lenses?.. Yes No
15. Have you taken steroids within the last 12 months? .... Yes No
16. Have you taken any medications for treatment of Osteoporosis?.. Yes No

Women

17. Are you pregnant?............Yes No In Which Month?............Yes No Are you nursing?............Yes No

I have read and understand the above. I will not hold the surgeon or his staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ____
Signature of Patient Witness

RECORD OF APPOINTMENTS AND TREATMENT

Date	Tooth	Description of Treatment	Debit

Date ___________________________

Louisville Dental Specialists

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Last First Middle

City ________________________ State _________ Zip Code __________ Home Phone _______________ Bus. Phone _____________

Cell Phone _________________ E-mail Address ________________________ Date of Birth ____________Age ______ Sex__________

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