



Health Form

Patient name:	_____
Address:	_____

Phone:	_____
Date of birth:	_____
Race (please check):	<input type="checkbox"/> White, <input type="checkbox"/> Black, <input type="checkbox"/> Asian, <input type="checkbox"/> Hispanic, <input type="checkbox"/> Am. Indian, <input type="checkbox"/> Other (please explain): _____

Have you ever had or do you now have any of the following?

	YES	NO		YES	NO
Heart trouble			Stroke		
Heart attack			Seizures		
Rheumatic fever			Venereal disease		
Heart murmur			Arthritis		
High blood pressure			TMD/TMJ		
Emphysema			Emotional		
Tuberculosis			Psychiatric treatment		
Asthma			Skin disease		
Diabetes			AIDS		
Ulcers			HIV +		
Intestinal trouble			Lupus		
Hepatitis B			Cancer (please explain below)		
Hepatitis (other)			IV treatment bisphosphonate		
Liver disease			Take Fosomax, Aredia, Actonel, Zometa, Boniva?		
Kidney or bladder disease			Other (please list below)		
Bleeding problems					
Sickle cell anemia					

What's the reason for the x-ray examination? (Please check)

THIS SIDE OFFICE USE ONLY

Dental implants		
TMD/ TMJ		
Wisdom teeth or tooth extraction in general		
Sinus disease		
Sinus surgery		
Jaw pain (upper or lower)		
Jaw swelling (upper or lower)		
Sleep apnea		
Orthodontic treatment (braces)		
Other (please explain below)		

To the best of my knowledge the above is complete and correct

Signature (patient, parent or guardian)	Date: