Patient Name: _____
First MI Last

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Date Of Birth: _____ SS#: _____ Sex: M F

Marital Status: _____ Email: _____

Emergency Contact: _____ Phone: _____

Referral Source: (Circle one) Phone Book, Internet, Visitor's Guide, Newspaper, Sign, or Current Patient (Name) _____ Other _____

Place a mark on "yes" or "no" to

AIDS/HIV	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Tuberculosis	❑Yes	❑No
ANEMIA	❑Yes	❑No	Heart Problems	❑Yes	❑No	Tumor or growth on		
Arthritis, Rheumatism	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No	Head/Neck	❑Yes	❑No
Artificial Heart Valves	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Ulcer	❑Yes	❑No
Artificial Joints	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
Asthma	❑Yes	❑No	Liver Disease	❑Yes	❑No			
Bleeding abnormally,	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Headaches	❑Yes	❑No
with extractions or surgery			Nervous Problems	❑Yes	❑No	Jaw Pain	❑Yes	❑No
Blood Disease	❑Yes	❑No	Pacemaker	❑Yes	❑No	Jaw Popping	❑Yes	❑No
Cancer	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	Limited Opening	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Congested Ears	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	Dizziness	❑Yes	❑No
Cortisone Treatments	❑Yes	❑No	Scarlet Fever	❑Yes	❑No	Ringing Ears	❑Yes	❑No
Cough, persistent	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Posture Problems	❑Yes	❑No
Diabetes	❑Yes	❑No	Stroke	❑Yes	❑No	Clenching	❑Yes	❑No
Epilepsy	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No	Grinding	❑Yes	❑No
Fainting or dizziness	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No	Facial Pain	❑Yes	❑No
Glaucoma	❑Yes	❑No	Thyroid Problems	❑Yes	❑No	Neck Ache	❑Yes	❑No
Heart Lesions	❑Yes	❑No	Tonsillitis	❑Yes	❑No	Bell's palsy	❑Yes	❑No

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

_____

_____

Are you allergic to any medications or other substances?

_____

_____

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

____yes ____no List Medication

_____

Do you use tobacco products? ____yes ____no

Signature: _____

Circle if you have seen: an Orthodontist -had your bite adjusted- had any bite related treatment - TMJ Joint Surgery

Circle if you have seen any of the following healthcare professionals: ENT, Neurologist, Chiropractor, or Massage Therapist.

Do you snore, use a CPAP or have had a sleep study?

_____yes _____no

Have you ever had radiation to the head and/or neck?

_____ yes _____ no

Date: _____