Name ______________________

Address ______________________

City & Zip ______________________

Phone # ______________________

Age ________ Birthdate ______________________

Sex ________ Marital Status ______________________

Soc. Sec. # ______________________

Spouse / Parent ______________________

Family Physician ______________________

Referred by ______________________

Employer ______________________

Address ______________________

City & Zip ______________________

Phone # ______________________

Insurance Co. ______________________

Insurance Group # ______________________

Phone # ______________________

In Case of Emergency (Relative or Friend) ______________________

____

Address ______________________

City & Zip ______________________ Phone ______________________

	Yes	No
1. Are you presently under a physician's care? If so, please specify ______________________	☐	☐
2. Are you presently taking any medications (prescription or over-the-counter)? If so, please specify ______________________	☐	☐

3. Do you, or have you had any of the following? Please check.

- ☐ Rheumatic Fever
- ☐ Heart Trouble
- ☐ Anemia
- ☐ Hepatitis / Type______
- ☐ Asthma
- ☐ Epilepsy
- ☐ Artificial Joints
- ☐ Headaches
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Kidney or Bladder Disease
- ☐ Hay Fever
- ☐ Immune System Disorder (Inc. AIDS, HIV, ARC)
- ☐ Ulcers
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Yellow Jaundice
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ TMJ Disorder
- ☐ Digestive Disease
- ☐ Sinus Problems

	Yes	No
4. If any of the above conditions are checked, is it or are they under control? If no, please specify ______________________	☐	☐

5. If you are allergic to any medication or anesthetic, please list and also list reaction.

____

6. If you have been hospitalized in the last 5 years, please list the reason and when this occured ______________________

____

	Yes	No
7. Have you ever had endodontic treatment before?	☐	☐

8. Do you need to premedicate prior to dental treatment for any of the following reasons? (please check)
☐ Heart Murmur or Mitral Valve Prolapse ☐ Joint Prosthesis (hip, knee, etc.) ☐ Rheumatic Fever or Rheumatic Heart Disease ☐ Congenital Heart Disease ☐ Cardiovascular Disease ☐ Heart Attack ☐ Stroke ☐ Prosthetic Heart Valve
If any of the above are checked, what do you premedicate with, and what is the regimen?

____

	Yes	No
9. Are you pregnant?	☐	☐
10. Are you taking birth control pills? If the answer is yes, please be advised that taking antibiotics can lessen the effect of the birth control pills.	☐	☐

11. Please list anything else in your medical history of significance ______________________

____

12. How do you plan to pay for today's visit?
☐ Cash ☐ Check ☐ Credit Card (MasterCard or VISA)

Please give at least 24 hours notice if you cannot keep your appointment, otherwise, you will be billed for services schedule

Patient's (Parent's) Signature ______________________ Date ______________

Bruce D. Schulman, D.D.S. ______________________ Date ______________

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