Please CIRCLE any of the following that apply to you

Pacemaker	**Heart Condition**	**High Blood Pressure**
Diabetes	**Bleeding Disorder**	**Lung Disease or TB**
Epilepsy	**Hepatitis**	**Artificial joint or valve**
HIV/AIDS	**Asthma**	**Pregnancy (due date?_____)**

Any OTHER DISEASE or HEALTH PROBLEM please *LIST* HERE_____ Have you been Hospitalized or had a serious illness in the past 5 years?_____ If so what was the problem and the name of your Primary Physician?

_____

PLEASE LIST OR PROVIDE A LIST OF ALL MEDICATIONS YOU ARE TAKING._____

_____

Please CIRCLE if you are ALLERGIC to any of the following

Latex Penicillin Aspirin Ibuprofen Codeine Sulfa

***Please LIST* any other ALLERGIES you have_____**

_____

Have you ever had an adverse reaction to dental anesthetic, Septocaine, Lidocaine, or Epinephrine?_____

Do you Smoke? _____ Dip Tobacco?_____

***Required* Emergency Contact - Name_____**
Relation to you_____ Cell #_____

Patient Signature_____/Dr.Signature_____