FRED H. LARSON, D.D.S.

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Name _____ Birthdate _____ Age _____
LAST FIRST

Address _____ City _____ Zip _____

Phone: Home _____ Work _____ Cell _____

E-mail _____ Emergency Contact _____

Employer Name _____ Business Address _____

Social Security No. _____ Driver's License No. _____

Husband's or Wife's Name _____ Employed By _____

Whom May We Thank for Referring You? _____ Name of Your M.D. _____

Do You Have Dental Ins. _____ If Yes, Name of Company and Plan No. _____

If you are completing this form for another person, what is your relationship to that person? _____

How do you feel about dental treatment? not at all anxious, anxious, very anxious, extremely anxious. ***PLEASE CIRCLE***

How do you feel about anesthesia? not at all anxious, anxious, very anxious, extremely anxious.

For the following questions, circle YES or NO, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... YES NO
2. Has there been any change in your general health within the past year? _____ YES NO
3. My last complete physical was on _____
4. Are you now under the care of a physician? _____ YES NO
   If so, what is the condition being treated? _____
5. The name and address of my physician is _____
   _____
6. Have you had any illness or operation that required hospitalization? ..... YES NO
   If so, What was the illness or operation? _____
7. Has a physician ever informed you that you had:
   - Damaged heart valves, artificial heart valves, knee or hip replacement, plastic or artificial arteries? ..... YES NO
   - Congenital heart defect(s) or murmur? ..... YES NO
   - Cardiovascular disease: heart trouble, heart attack, coronary insufficiency, coronary occlusion, hypertension, arteriosclerosis, or stroke? ..... YES NO
   - Respiratory disease ..... YES NO
   - High or Low Blood Pressure ..... YES NO
   - Rheumatic fever ..... YES NO
   - Do you have a cardiac pacemaker? ..... YES NO
   - Do you have an arrhythmia or an irregular heart beat? ..... YES NO
   - Has your physician ever told you to take antibiotics prior to dental therapy? ..... YES NO
   - Diabetes? ..... YES NO
   - Is your mouth frequently dry? ..... YES NO
   - Hepatitis, jaundice or liver disease? ..... YES NO
   - Have you ever been told not to donate blood? If YES, why? ..... YES NO
   - A.I.D.S., ARC, or tested positive for HIV? ..... YES NO
   - Arthritis or inflammatory rheumatism? ..... YES NO
   - Kidney disease? ..... YES NO
   - Nervous breakdown or psychotherapy? ..... YES NO
   - Alcoholism/Drug Dependence? ..... YES NO
   - Other? .....

8. If I could change my smile, I would:

_____ Make them whiter
_____ Repair chipped teeth
_____ Make them straighter
_____ Replace any old crowns or crowns that have dark edges at the gumline
_____ Other _____
_____ Replace missing teeth
_____ Close spaces
_____ Replace black mercury filling with tooth colored filling

9. Have you taken any "recreational" drugs in the past year, such as cocaine, crack, LSD, marijuana, etc.? ..... YES NO
   If so, what? _____ When? _____
10. Do you bleed easily, bruise easily, or have you had abnormal bleeding with previous extractions or surgery? ..... YES NO
11. Do you have any blood disorder, such as anemia? ..... YES NO
12. Are you taking any of the following? ***If YES please state reason, dosage, and frequency.***

Dilantin	YES	NO	_____
Antibiotics or sulfa drugs	YES	NO	_____
Anticoagulants (blood thinners)	YES	NO	_____
Medicine for high blood pressure (hypertension)	YES	NO	_____
Cortisone (steroids)	YES	NO	_____
Tranquilizers	YES	NO	_____
Aspirin or Ibuprofen	YES	NO	_____
Insulin, tolbutamide (Orinase) or similar drug	YES	NO	_____
Digitalis or drugs for heart trouble	YES	NO	_____
Nitroglycerin	YES	NO	_____
Oral contraceptive or other hormonal therapy	YES	NO	_____
Any other prescription or non-prescription medication	YES	NO	_____

13. Are you allergic or have you reacted adversely to:

Local or general anesthetics	YES	NO
Penicillin or other antibiotics	YES	NO
Sulfa drugs	YES	NO
Barbiturates, sedatives, Valium, Demerol, codeine, or sleeping pills	YES	NO
Aspirin	YES	NO
Iodine	YES	NO
Latex	YES	NO
Other		

14. Have you ever had any trouble associated with any previous surgery or anesthetic not mentioned? ..... YES NO
    If so, what? .....
15. Do you have any disease, condition or problem not listed above? ..... YES NO
    If so, what? .....

WOMEN

Are you pregnant?	YES	NO
Are you a nursing mother?	YES	NO

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore I have reviewed this health history carefully and have answered all questions to the best of my knowledge.

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff, and assume financial responsibility. I understand that a service charge of 1½ % (18% per year) will be charged on any balance due over ninety (90) days.

Signature _____ Date _____