DENTAL OFFICES OF

L.A. AND AARON LEATHERMAN, D.D.S., P.A.

DOCTORS OF DENTAL SURGERY

PATIENT'S NAME _____ BIRTHDATE _____ SEX _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

HOME # _____ CELL # _____ EMPLOYER _____

SS # _____ EMAIL _____

MARITAL STATUS _____ SPOUSE'S NAME _____

SUBSCRIBER'S DENTAL INS _____ ID # _____ DOB _____

PERSONAL HEALTH HISTORY

1. Has there been any change in your general health within the past year? YES NO
2. Approximate date of your last physical exam. _____
3. Are you now under the care of a physician? YES NO
   If so, what is the condition being treated? _____
4. The name and address of your physician. _____
5. Have you been hospitalized or had a serious illness or injury within the past five years? YES NO
6. Do you have or have you had any of the following: PLEASE CIRCLE

High Blood Pressure	Low Blood Pressure	Dizziness or Fainting Spells
Stroke	Asthma or Hay Fever	Diabetes
Kidney Trouble	Epilepsy or Seizures	Anemia
Cancer or Tumor	Venereal Disease	Fever Blisters or Canker Sores
Swollen Glands in Neck	Tuberculosis	Arthritis

7. Have you had unexpected weight loss in the last three years? YES NO
8. Have you ever had Hepatitis B? YES NO
9. Do you have any of the following conditions involving the heart? Heart Murmur, Heart Valve Replacement, Mitral Valve Prolapse, Cardiac Pacemaker, Heart Bypass, Heart Surgery or Rheumatic Fever
10. Do you have a total or partial prosthetic device? Hip Joint Replacement or Knee Joint Replacement
11. Women only: Are you pregnant? YES NO
12. Do you require premedication? YES NO
13. Are you HIV positive? YES NO

DENTAL HEALTH HISTORY

1. Are you allergic to or have you reacted adversely to: PLEASE CIRCLE

Local Anesthetics	Penicillin or other Antibiotics	Barbiturates	Aspirin
Sulfa Drugs	Sedatives	Codeine	Other

2. Have you had abnormal bleeding associated with previous extraction, surgery or trauma? YES NO
3. Are you now taking any drugs or medications? YES NO If so, what? _____
4. Do you have any disease, condition, or problem not listed above that you think we should know about? YES NO
   If so, please explain. _____
5. Approximate date when teeth were last cleaned: _____
6. Do you use dental floss daily? YES NO
7. Do your gums bleed while bushing or flossing? YES NO
8. How often do you have your teeth cleaned and checked? _____
9. If patient is a minor, would you consent to the following treatments? ____ X-Rays ____ Fluoride Treatments ___ Sealants

REFERRED BY _____ PURPOSE OF CALL _____

We are a fee for service office. Regardless of insurance payment you are responsible for the full balance due. I hereby authorize this office to release any and all medical records as indicated , and that the above information is correct to the best of my knowledge.

SIGNED _____ DATE _____