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Patient Name:____Address:____zip code:______________

Birth Date: _______________Home Phone: ____________________Work Phone:__________________ Social Security:___________________________________

Employee Name: ____ Social Security:______________________________ Birth Date:_______________

Employer's name:______________________________Insurance ompany:__________________________________ Group Number: __________________________

Date of last dental check up?________________________Reason for this visit?____

I. CIRCLE APPROPRIATE ANSWER

1. Yes No Is your general health good?
2. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? ____
3. Yes No Are you being treated by a physician now? Why?____

III. DO YOU HAVE OR HAVE YOU HAD?

4. Yes No Chest pain (angina) heart disease?
5. Yes No Bleeding problems, bruising easily?
6. Yes No Aids?
7. Yes No Tumors, cancer?
8. Yes No Stroke, hardening of the arteries?
9. Yes No Diabetes?
10. Yes No Hepatitis, other liver disease?
11. Yes No Stomach problems, ulcers?
12. Yes No Are you allergies to drugs, foods, medications, latex?
13. Yes No osteoporosis?
14. Yes No Seizures?
15. Yes No Heart attack, heart defects?
16. Yes No Arthritis, rheumatism?
17. Yes No High blood pressure?
18. Yes No Asthma, TB, emphysema
19. Yes No Herpes?
20. Yes No Kidney, bladder disease?

Please List all allergies:____

IV. DO YOU HAVE OR HAVE YOU HAD:

21. Yes No Psychiatric care?
22. Yes No Radiation treatments?
23. Yes No Prosthetic heart valve?
24. Yes No Artificial joint such as a knee or hip? **IF YES DATE PLACED?**_____________________
25. Yes No Hospitalization?
26. Yes No Chemotherapy?
27. Yes No Pacemaker?

V. ARE YOU TAKING:

28. Yes No Recreational drugs?
29. Yes No Drugs, medications, over-the-counter, herbals?
30. Yes No Tobacco in any form?
31. Yes No Alcohol?

PLEASE LIST ALL MEDICATIONS, HERBALS, AND OTHER THE COUNTER MEDICINES YOU TAKE BELOW

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VI. WOMEN ONLY:

32. Yes No Are you or could you be pregnant or nursing?
33. Yes No Taking birth control pills?

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Gonsman of any change in my health and/or medication. I authorize the release of any information to my insurance company relating to claims made on my Behalf. I authorize payment directly to Dr. Richard Gonsman of group insurance benefits otherwise payable to me and agree to make all co-payments and pay any collections costs incurred by Dr. Gonsman if my account becomes more than 60 days past due .

There is a charge for Appointments cancelled without 24 hours notice unless an illness has occurred. Please call immediately if you have a schedule conflict.

Patient's or Guardian's signature:____Date:_____________________

Dr Gonsman's signature:____Date:_____________________