Date: _____

Patient's Name: _____

Please review all pages of this form and answer the following questions. Please sign and date this section.

Health History? (Include any/all medications or recently diagnosed medical conditions such as drug allergies):

_____
_____
_____
_____

Female patients over the age 14: Is there any possibility of pregnancy?

_____
_____

Name, Address or Telephone Number Changes?

_____
_____
_____
_____

Employment Changes?

_____
_____

Dental Insurance Changes?

_____
_____

Best phone number to reach you #: _____

Whose number is this? _____

Email Address: _____

_____

Parent Signature