PLEASE CIRCLE ANY OF THE FOLLOWING DISEASES OR CONDITIONS YOU HAVE EVER HAD OR PRESENTLY HAVE:

Jaundice	Anemia	Family History of Diabetes
Hepatitis - Type_____	Swollen Ankles	Kidney Disorder
Tuberculosis	Ulcers	Arthritis
Venereal Disease	Epilepsy	Skin Disease
Heart Attack/Trouble	Diabetes (Sugar Disease)	Glaucoma
Pacemaker	Rheumatic Fever	Liver Disease
Stroke	Painful or Swollen Joints	Bladder Infections
High Blood Pressure	Persistent Cough	Thyroid Trouble
Low Blood Pressure	Asthma/Emphysema	HIV/AIDS
Chest Pain on Exertion	Hay Fever	Other:_____
Unnatural Shortness of Breath	Sinus Problems	
Latex Sensitivity	Cancer	

PLEASE CIRCLE THE CORRECT RESPONSE:

1. Have you ever experienced an unusual reaction to a dental anesthetic ("Novocaine")? ..... YES NO
2. Have you ever had or are you presently undergoing psychiatric care? ..... YES NO
3. WOMEN--Are you pregnant at the present time? ..... YES NO
4. WOMEN--Are you in or have you passed through the menopause (change of life)? ..... YES NO
5. **WOMEN--Have you ever been treated for osteoporosis, osteopenia or post-menopausal bone loss?** ..... YES NO
   If so, what drugs were prescribed: _____
6. WOMEN--Have you had a hysterectomy or ovariectomy? ..... YES NO
7. WOMEN--Are you currently taking birth control pills? ..... YES NO

HAVE YOU EVER EXPERIENCED AN ALLERGIC REACTION TO ANY OF THE FOLLOWING? PLEASE CIRCLE

Penicillin	Aspirin	Demerol
Codeine	Sulfa	Others:_____
Barbiturates (Sleeping Pills)	Valium	No Known Allergies _____

DENTAL HISTORY

1. How often do you have your teeth cleaned?_____ When was the last time you had your teeth cleaned? _____
2. Have you had previous periodontal treatment? ..... YES NO
   If yes, what? _____ When?_____
3. How often do you brush your teeth?_____
4. Do you use a hard, medium, or soft toothbrush? _____
5. Do you use any other oral hygiene devices or materials? ..... YES NO
   If yes, what and how often? _____
6. Do your gums bleed when you brush your teeth? ..... YES NO
7. Are you aware of bad breath?..... YES NO
8. Have you noticed your gums receding?..... YES NO
9. Do you have discomfort in your mouth now?..... YES NO
10. Have you ever had any complications to dental treatment? ..... YES NO
    If yes, what? _____

CIRCLE ANY OF THE FOLLOWING ORAL HABITS OF WHICH YOU ARE AWARE:

Clenching or grinding teeth Habitual lip, cheek, or tongue biting

Smoking (How much?_____) Smokeless Tobacco Other _____

Is there any other information which will help us to help you? _____

I agree to pay any balance for services rendered in this office regardless of any insurance coverage. In the event my account becomes delinquent, I agree to pay any necessary collection and attorney's fees of no less than 40% added to the unpaid balance and court costs. There will be a $40 handling fee for all returned checks.

In the event this account is involved in litigation, I expressly waive any objection to venue and set venue will be Knox County, Tennessee.

Signature_____ Date_____