Richard Angell III DMD, MSD
PRACTICE LIMITED TO ENDODONTICS

REGISTRATION AND HEALTH HISTORY

(PLEASE PRINT LEGIBLY)

(Mr./Mrs./Ms. Miss/Dr.) Last Name _____ First Name _____ Gender M / F Date _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Street Address _____ City/ State/ZIP _____ Birth Date _____

Social Security # _____ (and/or) Driver's License # (and State) _____

Family Dentist _____ Family Physician _____ Date of Last Physical Exam _____

Employer Name/City _____ Occupation _____

1. Has there been any change in your general health with the past year?..... Yes___No___
   If so, please explain _____
2. Are you under the care of a physician for a current problem?..... Yes___No___
   If so, please explain _____
3. Have you been hospitalized within the past 5 years?..... Yes___No___
   If so, please explain _____
4. Have you ever had surgery and/or radiation for a tumor, growth or other condition?..... Yes___No___
   If so, please explain _____
5. Are you taking any medications or drugs?..... Yes___No___
   If so, please list _____
6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthesia/antibiotics/medications?..... Yes___No___
   If so, please list _____
7. Are you required to take antibiotics prior to EVERY dental treatment/visit?..... Yes___No___
   If so, state name of medication, how many tablets taken and at what time _____
   _____
8. Have you had abnormal bleeding with previous extractions, surgery, or trauma?..... Yes___No___
   If so, please explain: _____
9. Have you ever required a blood transfusion?..... Yes___No___
   If so, please explain _____
10. Have you ever tested positive for HIV infection or AIDS?..... Yes___No___
11. Have you received therapy for alcoholism or drug addiction within the past 5 years?..... Yes___No___
12. (Women only) Are you pregnant, nursing or using birth control of any form?..... Yes___No___
13. Do you have or have you ever had any of the following?

___High blood pressure	___Allergy to latex	___Temporomandibular joint problems
___Cardiovascular disease (heart attack/stroke/bypass)	___Asthma	___Cancer
___Congenital heart disease	___Diabetes	___Thyroid problems
___Rheumatic fever or rheumatic heart disease	___Sinus trouble	___Stomach ulcers, colitis
___Heart murmur or prolapsed valve	___Psychiatric treatment	___Hepatitis, jaundice, liver disease
___Prosthetic heart valve	___Fainting spells or seizures	___Blood disorder (e.g., anemia)
___Joint prosthesis (hip, knee, etc.)	___Epilepsy	___Venereal disease

14. Do you have any disease, condition or problem not listed above?..... Yes___No___
    If so, please explain _____

I affirm that the above information is true and correct to the best of my knowledge. I hereby authorize payment directly to Dr. Richard Angell III of the group/individual insurance benefits otherwise payable to me.

_____

PATIENT SIGNATURE (parent or guardian if patient is under 18 years of age)