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Gary A. Minchau, D.M.D. **www.go2hilltopdental.com**

NAME (LAST, FIRST): ____________________ ______________ TITLE: ____________

ADDRESS: ______________________________ __________________________________

SS NO: _________ _____ DOB: ___/___/___ HOME PHONE: ____________________

WORK PHONE: _______________________ CELL PHONE: __________________________

CHECK ANY THAT APPLY:

YES	NO		YES	NO		YES	NO	
____	____	ARTHRITIS	____	____	HEPATITIS	____	____	PROLONGED BLEEDING
____	____	RHEUMATIC FEVER	____	____	LIVER DISEASE	____	____	FAINTING TENDENCY
____	____	HEART TROUBLE	____	____	CANCER	____	____	EPILEPSY
____	____	HEART MURMUR	____	____	TUBERCULOSIS	____	____	THYROID DISEASE
____	____	HIGH/LOW BLOOD PRESSURE	____	____	DIABETES	____	____	GLAUCOMA
____	____	ASTHMA OR HAY FEVER	____	____	KIDNEY TROUBLE	____	____	RADIATION TREATMENT
____	____	CHEST PAIN	____	____	ANEMIA	____	____	MENTAL DISORDERS
____	____	STROKE	____	____	LUNG DISEASE	____	____	HIV OR AIDS
____	____	SHORTNESS OF BREATH	____	____	BLOOD DISEASE	____	____	VENEREAL DISEASE
____	____	SINUS TROUBLE	____	____	BLOOD TRANSFUSION			
____	____	PROSTHETIC JOINT REPLACEMENT						

Check any of the following medications that you **are** or **have taken**:

YES	NO		YES	NO		YES	NO	
____	____	BISPHOSPHONATE DRUGS	____	____	SEDATIVES	____	____	TRANQUILIZERS
____	____	CORTISONE DRUGS	____	____	STEROIDS	____	____	ANTICOAGULANTS
____	____	BLOOD THINNERS						
____	____	OTHER____________________________						

Are you allergic or do you become ill from the following:

YES	NO		YES	NO		YES	NO	
____	____	PENICILLIN	____	____	CODEINE	____	____	DENTAL ANESTHESIA
____	____	ASPIRIN	____	____	LATEX	____	____	HOUSEHOLD BLEACH
____	____	OTHER____________________________						

Who may we thank for referring you to our office?________________________________

NAME:______________________________________DATE:___________________

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.