Justin E. Aurbach, D.D.S., Inc.

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Phone 972-233-9772 Fax 972-934-1617

Patientôs Name_____ Todayôs Date_____ Date of Birth_____

Marital Status_____ SS#_____ DL#_____ E-Mail _____

Address_____ City/St_____ Zip_____

Home #_____ Work#_____ Cell#_____

Employer_____ Occupation_____ Employer Address_____

Spouseôs Name_____ Employer_____ Work #_____

Person responsible for Payment_____ Phone #_____

If patient is a minor, parentôs or guardianôs name_____

Dental Insurance Coverage_____ Medical Coverage_____

Referred by_____ General Dentist_____

Physicianôs Name_____ Physicianôs Phone # _____

Health History

All answers are for our records only and will be confidential

Medical Condition (Please circle yes/no)	**Date** (comments/update)	**Medical Condition** (please circle yes/no)	**Date** (comments/update)
Heart Problems	Yes No _____	Ulcers	Yes No _____
High Blood Pressure	Yes No _____	Diabetes	Yes No _____
Low Blood Pressure	Yes No _____	Thyroid Problems	Yes No _____
Mitral Valve Prolapse	Yes No _____	Glaucoma	Yes No _____
Rheumatic Fever	Yes No _____	Do you smoke	Yes No _____
Arthritis	Yes No _____	(how much)	
Rheumatism	Yes No _____	Emphysema	Yes No _____
Artificial Joint	Yes No _____	Tuberculosis	Yes No _____
(hip, knee, etc.)		Asthma	Yes No _____
Drug/Alcohol addiction	Yes No _____	Hay Fever	Yes No _____
Stroke	Yes No _____	Allergies or Hives	Yes No _____
Kidney	Yes No _____	Sinus Trouble	Yes No _____
Cancer	Yes No _____	Hepatitis	Yes No _____
Venereal Disease	Yes No _____	HIV/Aids	Yes No _____
Liver Disease	Yes No _____	Epilepsy/Seizures	Yes No _____
Faint Easily	Yes No _____	Nervousness/Anxiety	Yes No _____
Psychiatric Treatment	Yes No _____		
Excessive thirst or hunger		Change in frequency of	
Over long period of time	Yes No _____	urination?	Yes No _____
Problems with bleeding			
Or clotting	Yes No _____		

Please circle any of the following medications you are allergic to:

Aspirin	Erythromycin	Novocaine	Phenergan	Versed	Vicodin (hydrocodone)
Carbocaine	Kflex/Keflin	Penicillin	Tetracycline	Xylocaine	Other
Codeine	Motrin	Percodan	Tylenol	Sulfa	_____

Please list any drugs you are currently taking:

Have you ever been treated for depression? If so when _____

Have you ever been treated for neurologic disorder or problem? _____

Emergency Contact Information: Name _____ Phone# _____

Women Only

Are you pregnant Yes / No

Have you given birth to a baby with a birth weight of 9lbs or more? Yes / No

Have you had a hysterectomy or ovariectomy? Yes / No

If you are pregnant:

How many weeks _____

Name of OB-Gyn _____

Phone # of Dr. _____

Men Only

Do you have prostate problems? Yes / No

Do you have any disease, condition, or medical problem not listed above that you think we should know about or that you believe might affect your treatment?

Signature of patient, guardian or parent, if minor:

_____Date_____

B.P._____ **Pulse**_____ **Temp.**_____**RR**_____