AUDUBON
DENTAL CENTER

PRELIMINARY HEALTH HISTORY FORM

NAME:________________________________ DATE:________________
ADDRESS:____
CITY: ____________________ STATE: _____ ZIP: ____________________
HOME PHONE: ________________ BIRTHDATE: ____________________
WORK PHONE: ________________ CELL PHONE: ____________________
OCCUPATION/EMPLOYMENT: __________________________________
SOCIAL SECURITY NUMBER: ____________________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? (circle one)

TV RADIO DIRECT MAIL FRIEND/FAMILY OTHER

WHAT IS YOUR EMAIL ADDRESS? ______________________________

ARE YOU **ALLERGIC** TO ANY **MEDICATIONS**? ____________________
____
ARE YOU ALLERGIC TO **LATEX**? __________________________________

DO YOU HAVE, OR HAVE YOU HAD HEART TROUBLE, HEART MURMUR, RHEUMATIC FEVER, VALVE DISEASE/REPLACEMENT, OR MITRAL VALVE PROLAPSE? (OR ANY OTHER CONDITION REQUIRING **PREMEDICATION** WITH ANTIBIOTICS? ____

WHEN WAS THE APPROXIMATE DATE OF YOUR LAST DENTAL CLEANING?
____

NAME AND TOWN OF CURRENT DENTIST: ___________________________