Lubus Dentistry Professional Corporation

In order to render an optimum health service it is necessary to obtain a variety of vital personal information. All information obtained is of course confidential. **Please print all information**

Name: ______________________________ Birthdate: ______________

Address: ______________________________

Postal Code: ______________________ Phone (home) ______________

Employer: ______________________ Phone (work) ______________

Health card #: ______________________ Phone (cell) ______________

Name of Insurance Company: ______________________________

Whom may we thank you your referral? ______________________________

Name of Physician: ______________________ Phone: ______________

1. To the best of your knowledge, are you in good health: ___Yes ___No
2. a) Are you presently under treatment or observation by a physician: ___Yes ___No

   b) Date of last complete physical examination: ______________________
3. Are you taking any medication prescribed or self-administered?
4. Medications ______________________ Reason? ______________

   Have you experienced an unusual reaction to any of the following medications?

	Yes	No		Yes	No		Yes	No
Penicillin	__	__	Other Antibiotics	__	__	Aspirin	__	__
Sulfa Drugs	__	__	Codeine	__	__	Local Anesthesia	__	__

5. Do you have any allergies? ______________________________
6. Do you have or have you had any of the following:

CVS	**Yes**	**No**
Rheumatic Fever	___	___
Hearth Murmur	___	___
Heart Disease	___	___
Chest Pains	___	___
Shortness of breath	___	___
Swelling of the ankles	___	___
Abnormal blood Pressure	___	___
Headaches	___	___
Blood Abnormalities		
Tested positive for HIV	___	___
Tend to Bruise-Bleed Easily	___	___
Prolonged Bleeding Episodes	___	___
Blood Disorders	___	___
Had Blood Transfusion	___	___
Respiratory Disease		
Sinusitis	___	___
Asthma	___	___
Bronchitis	___	___
Tuberculosis	___	___
CNS		
Epilepsy	___	___
Tendency to Faint	___	___
Fits or Convulsions	___	___

Kidney Disease	**Yes**	**NO**
Recurring Kidney Infections	___	___
Kidney Stone	___	___
Void more than 6x/day	___	___
Liver Disease		
Cirrhosis	___	___
Jaundice	___	___
Hepatitis	___	___
G.I. Disease		
Food Intolerances	___	___
Medicine Intolerances	___	___
Ulcers	___	___
Endocrine		
Diabetes	___	___
Thyroid Problems	___	___
Weight Loss in Short Period of Time	___	___
Ocular Diseases		
Glaucoma	___	___
Frequent Eye Problems	___	___
Women Only		
Are you Pregnant?	___	___
If Yes, In what stage of Pregnancy?		
Are you taking Oral Contraceptives/Hormones		

7. Have you ever been hospitalized?

   Year______________________ Purpose of Stay______________________

   Hospital ______________________ Dr. in Charge______________________

I believe the above information to be true and correct. I authorize the Doctor and the assistants that he delegates to perform any dental and oral surgical procedures including the use of radiography's (x-rays) and drugs, that he feels necessary for my oral health, and I assume the responsibility for fees associated with those procedures.

Date: ______________________ Signature: ______________________