EDWARD YALISOVE, D.M.D.

HEALTH HISTORY-

Name: _____ **Date of Birth:**_____

Address:_____ **City**_____

State_____ **Zip Code**_____

Phone Number:_____ **Social Security #:**_____ **Cell #**_____

E-mail_____ **Employer**_____
When was your last dental visit? _____

For what service?_____ **Are you in pain?**_____

Your Physician's Name_____ **Phone #**_____

Are you taking any medication? If so, please list (If you have a list, please present to receptionist)

_____

Do you have any allergies? Medicine? Food? Latex?_____

Have you ever had or do you have any of the following?

__Heart Disease/Attack	__Diabetes	__Joint Replacement Hip, Knee or other (circle) Replacement	
__Heart Murmur	__Kidney Disease	__Cancer/Tumor/Swelling	__Chemotherapy
__Heart Surgery	__Asthma	__Emphysema	__Radiation Therapy
__Shortness of Breath	__Pacemaker	__Rheumatic Fever	__Hepatitis
__Stroke	__Headaches	__Sinus Trouble	__Anxiety
__HIV/AIDS	__Drug Addiction	____Fever blisters	
__Eating Disorder	__Epilepsy	__Seizures	__High/Low Blood Pressure

Is there anything else about your medical condition we should know?_____

I certify that the above information is correct _____**Date**_____
Patient Signature

Dental Insurance: Please provide information to receptionist