# BARBARA BILDER D.M.D.

Prosthetic, Esthetic & Implant Dentistry

NAME _____
LAST FIRST MIDDLE DATE

Address _____ Date of Birth _____
City _____ State _____ Zip Code _____
Home Phone _____ Marital Status _____
Email Address _____ Cell Phone _____
Emergency Contact _____ Phone _____
If completing this form for another person, what is your relationship to that person? _____
Briefly explain your immediate dental concern _____

Employer _____ Occupation _____
Employer Address _____ Phone_____
City _____ State _____ Zip Code _____

**Please circle YES or NO:**

1. Are you in good health? ..... **YES** **NO**
2. Are you currently under the care of a physician? ..... **YES** **NO**
   If so, what is the condition being treated? _____
3. Have you been hospitalized? ..... **YES** **NO**
   If so, for what condition _____
4. Do you have heart trouble or any form of cardiovascular disease? **YES** **NO**

___ Angina (chest pains) Frequency_____
___ Heart Attack: Date _____
___ Heart Surgery: Date _____
___ Rheumatic Fever: Date _____
___ Stoke: Date _____
___ High Blood Pressure
___ Congenital Heart Lesions
___ Pacemaker
___ Bypass
___ Atherosclerosis
___ Heart Murmur
___ Prosthetic Heart Valve
___ Other: List Below
_____

5. Do you have or have you had any blood disease? **YES** **NO**

___ Excessive Bleeding ___ AIDS or positive test ___ Leukemia
___ Venereal Disease ___ AIDS Related Complex (ARC) ___ Anemia
___ Other: Please List _____

6. Do you have any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Diabetes? | **YES** | **NO** | Emphysema, Asthma or breathing problem? | **YES** | **NO** |
| Hypoglycemia? | **YES** | **NO** | Arthritis (Rheumatoid, Osteoarthritis)? | **YES** | **NO** |
| Kidney Disease? | **YES** | **NO** | Hip or joint replacement? | **YES** | **NO** |
| Glaucoma? | **YES** | **NO** | Liver disease or Jaundice? | **YES** | **NO** |
| Stomach Ulcer? | **YES** | **NO** | Fainting spells, convulsions, epilepsy? | **YES** | **NO** |
| Intestinal Ulcer? | **YES** | **NO** | Surgery, radiation, or other treatment for cancer? | **YES** | **NO** |
| Tuberculosis? | **YES** | **NO** | Injury or pain from your jaw joint (TMJ)? | **YES** | **NO** |
| Hepatitis? | **YES** | **NO** | Chronic head, neck, or back pain problems? | **YES** | **NO** |
| __ Type A Infectious (food) | | | Trauma to your head or neck? | **YES** | **NO** |
| __ Type B Serum (blood) | | | | | |
| __ Type C | | | | | |


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*A history of excellence continues...*