



PATIENT INFORMATION
Today's Date:
Patient's Name: Title: Date of Birth:
Preferred Name: Email Address:
Street Address: City/State/Zip:
Home Telephone: Work Telephone: Cell Phone:
Patient's Employer: Occupation:
Patient's SS #: Spouse/Partner's SS #:
Spouse/Partner's Name: Date of Birth:
Spouse/Partner's Employer: Occupation:
Person Responsible for Account: Relationship to Patient:
Dental Insurance: Policy/Subscriber #:
Dental Insurance Address: Telephone:

PLEASE NOTE: By providing the above contact information, you agree that the information is correct, and you agree for our office to utilize this information to contact you regarding any communication.

Emergency Contact Person: Contact Telephone #:

PLEASE NOTE: By listing a contact person above, you agree for our office to disclose any and all pertinent information regarding your care to this person in the event of an emergency.

General Dentist: Date of Last Dental Exam:

Medical Physician: Date of Last Medical Exam:

Physician's Telephone #:

Reason for your visit today:

MEDICAL HISTORY

1. Are you under the care of another physician? YES or NO If Yes, Why?

2. Have you been hospitalized for any surgical operation or serious illness? YES or NO If Yes, When?

3. Are you taking any medications or supplements? YES OR NO If Yes, Please list names:

4. Please circle any of the following medications listed below for Osteoporosis, Osteopenia, or as Cancer Therapy that you have taken in the past:

Fosamax Boniva Actonel Zometa Aredia Bonefos Didronel Other:

5. Are you currently taking any blood thinners (this includes Aspirin, Plavix, Coumadin)? YES or NO If yes, What?

6. Have you ever been instructed by a doctor to PRE-MEDICATE with antibiotics prior to going to the dentist due to a heart condition or joint replacement? YES or NO If Yes, What have you been prescribed?

7. Are you currently using tobacco products? **YES or NO** If Yes, What type? _____ How Often? _____

8. Are you **allergic** or have you **reacted adversely** to: (Check, if any)

- Local Anesthetics Penicillin Sulfa Codeine Latex Demerol Aspirin Other Antibiotics

Please list any other drug _____

9. Do you drink **alcohol** in excess or have you ever been **treated for alcohol abuse**? YES or NO If Yes, please explain: _____

10. Do you use **recreational drugs** or **medications not prescribed** by your physician? **YES or NO** If Yes, please explain: _____

11. **WOMEN ONLY:** Are you pregnant? **YES or NO** Are you nursing? **YES or NO** Do you take birth control pills or hormone pills? **YES or NO**

Do you have or have you had any of the following?

Heart Disease/Heart Attack.....	YES or NO	High Blood Pressure	YES or NO
Angina/Chest Pains.....	YES or NO	Heart Infection/Endocarditis	YES or NO
Heart Surgery/Stents.....	YES or NO	Peripheral Vascular Neuropathy	YES or NO
Cardiac Pacemaker.....	YES or NO	Rheumatic Fever/Mitral Valve Prolapse/Murmur	YES or NO
Asthma/Shortness of Breath.....	YES or NO	Emphysema.....	YES or NO
Tuberculosis.....	YES or NO	Chronic Obstructive Pulmonary Disease	YES or NO
Fainting Spells/Seizures.....	YES or NO	Epilepsy/Convulsions	YES or NO
Stroke/Transient Ischemic Attacks (TIAs).....	YES or NO	Fibromyalgia	YES or NO
Organ Transplant.....	YES or NO	AIDS/HIV Positive.....	YES or NO
Diabetes.....	YES or NO	MRSA/VRSA.....	YES or NO
Hepatitis: Circle Type A B C	YES or NO	Thyroid/Parathyroid Problems	YES or NO
Liver Disease/Jaundice.....	YES or NO	Anxiety.....	YES or NO
Radiation Therapy/Chemotherapy	YES or NO	Anemia	YES or NO
Irritable Bowel Syndrome/Colitis/Diverticulitis.....	YES or NO	Crohn's Disease	YES or NO
Acid Reflux/Peptic Ulcer Disease.....	YES or NO	Swollen Ankles.....	YES or NO
Kidney Disorders/Stones.....	YES or NO	Arthritis.....	YES or NO
Joint Replacement/Joint Implants.....	YES or NO	Narrow Angle Glaucoma.....	YES or NO
Sleep Apnea.....	YES or NO	Other Condition(s) not listed _____	YES or NO
Cancer: List Type _____	YES or NO	_____	_____
FOR DOCTOR'S USE ONLY			

AUTHORIZATION and RELEASE

I certify that I have read and understand the above information and to the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor/doctors in this practice to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient (or parent if patient is a minor): _____

Medical History Reviewed By: _____ Date: _____