Patient Information:

Name _____ Date of Birth _____ Sex M / F

Phone # Home _____ Cellphone _____

Address _____ City /State _____ Zip _____

SS# _____ Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Emergency Contact _____

Relationship _____ Phone # _____

Employer _____ Phone # _____

Do you have Dental Insurance? Yes / No If yes, please provided a copy to the front office.

What is the reason for your visit today?

_____

How do you feel about your smile?

_____

Medical Information :

Preferred Pharmacy _____

Are you taking any prescriptions or over the counter medicine? Yes / No

If yes, please list:

_____

_____

_____

_____

Do you use controlled substances (drugs)? Yes / No

Do you use tobacco (smoking , snuff, chew) ? Yes / No

If so, how interested are you in stopping? Very / Somewhat / Not Interested

Do you drink alcoholic beverages? Yes / No

If yes, how much in the last 24 hours? _____

How much do you typically drink in a week ? _____

Are you taking or scheduled to begin taking the medications denosumab (**Prolia**), aledrontate (**Fosamax**) or risendronate (**Actonel**) for osteoporosis or Paget's disease?

Yes / No

Since 2001,were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (**Aredia** or **Zometa**) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastic cancer? Yes / No Start Date of Treatment _____

Women ONLY – Are you pregnant? Yes / No Number of weeks? _____
Taking birth control or hormone replacement? Yes / No Nursing? Yes / No

See Reverse Side ->

Allergies – Are you allergic to any of these? If yes please list what type of reaction.

Barbiturates, Sedatives, or Sleeping Pills_____ Yes / No

Local Anesthetics _____ Yes / No Aspirin _____Yes / No

Penicillin or other antibiotics_____Yes / No Sulfa Drugs _____Yes / No

Codeine or other Narcotics _____Yes / No Metals _____Yes / No

Latex (rubber) _____Yes / No Iodine _____ Yes / No

Hay Fever/Seasonal _____ Yes / No Animals _____Yes / No

Food _____ Yes / No Other _____Yes / No

Have you had/have any of the following medical conditions, if yes, please circle or check :

Heart Murmur	Anemia	Diabetes Type 1 or 2	Neurological Disorder
Mitral Prolapse	Blood Transfusion	Eating Disorder	If yes, specify_____ __
Artificial Heart Valves	If yes, Date:_____	Malnutrition	Sleep Disorder
Rheumatic Fever	Hemophilia	Gastrointestinal Disease	Mental Health Disorder
Cardiovascular Disease	AIDS or HIV Infection	G.E Reflux / Heartburn	If yes, specify_____ ___
Angina	Arthritis	Ulcers	Recurrent Infections
Arteriosclerosis	Autoimmune Disease	Thyroid Problems	Type? _____
Congestive Heart Failure	Rheumatoid Arthritis	Stroke	Kidney Problems

Coronary Artery Disease	Systemic Lupus Erythematosus	Glaucoma	Night Sweats
Damaged Heart Valves	Asthma	Hepatitis	Osteoporosis
Heart Attack	Bronchitis	Jaundice	Persistent Swollen Glands
High Blood Pressure	Emphysema	Liver Disease	Severe Headaches
Low Blood Pressure	Sinus Trouble	Epilepsy	Migraines
Congenital Heart Defects	Tuberculosis	Fainting or seizures	Rapid Weight Loss
Pacemaker	Cancer / Chemo / Radiation		STD /STI
Rheumatic Heart Disease	Chest Pain upon Exertion		Excessive Urination
Abnormal Bleeding	Chronic Pain		

Do you have any disease, condition, or problem not listed that we should know about? Yes / No
If yes, please explain_____
_____

Joint Replacement – Have you had an orthopedic total joint replacement (hip,knee,elbow,finger)? Yes / No
Date _____ If yes, have you had any complications?
_____
Has a physician or previous dentist recommend that you take antibiotics prior to your dental treatment Yes / No
Name of recommending doctor _____ Phone #
_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or another member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian _____
Date _____