

**WELCOME TO OUR OFFICE**

Female  
 Male

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name you like to be called: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Name of general dentist: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

What can we do to make your appointments with us more comfortable? \_\_\_\_\_

\_\_\_\_\_

<p><b>Person to contact in case of emergency:</b> _____ Phone: ( ) _____</p> <p>Address: _____ City: _____ State: _____ Zip: _____</p>
----------------------------------------------------------------------------------------------------------------------------------------

**MEDICAL HISTORY**

How would you rate your general health?      Excellent      Good      Fair      Poor

Do you smoke? No \_\_\_\_\_ Yes \_\_\_\_\_      How much? \_\_\_\_\_

Are you currently under the care of a physician? No \_\_\_\_\_ Yes \_\_\_\_\_      If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Name of your physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Date of last complete exam: \_\_\_\_\_

Have you been hospitalized or had surgery in the past year? No \_\_\_\_\_ Yes \_\_\_\_\_      If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

(over)

Are you allergic to or have you reacted adversely to any of the following medications? N / Y

If YES, please check the appropriate medications:

\_\_\_ASPIRIN \_\_\_TYLENOL \_\_\_CODEINE \_\_\_LOCAL ANESTHETIC (Novocaine or Xylocaine)  
\_\_\_ERYTHROMYCIN \_\_\_TETRACYCLINE \_\_\_PENICILLIN \_\_\_LATEX \_\_\_AMOXICILLIN

Are you aware of being allergic to any other medication or substance? N / Y If YES, please explain:

**Do you take aspirin regularly? N / Y Dosage \_\_\_\_\_ Are you subject to prolonged bleeding? N / Y**

Please list all medications you are currently taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

Please check any of the following which you have had or have at the present:

___MITRAL VALVE PROLAPSE	___ASTHMA	___YELLOW JAUNDICE
___ARTIFICIAL HEART VALVE	___ANGINA PECTORIS	___LIVER DISEASE
___RHEUMATIC or SCARLET FEVER	___HIGH BLOOD PRESSURE	___ULCERS
___HEART MURMUR	___HIGH CHOLESTEROL	___FEVER BLISTERS
___HEART FAILURE OR DISEASE	___THYROID DISEASE	___HEMOPHILIA
___HEART SURGERY	___KIDNEY TROUBLE	___BLOOD TRANSFUSION
___JOINT REPLACEMENT (HIP, KNEE)	___CANCER	___DRUG ADDICTION
___SYNTHETIC VASCULAR GRAFT	___RADIATION OR CHEMOTHERAPY	___ARTHRITIS
___INFECTIOUS ENDOCARDITIS	___TUBERCULOSIS	___DIABETES
___HEMODIALYSIS PATIENTS W/ FISTULA OR SHUNT NEURO-SURGICAL SHUNT	___HIV POSITIVE	___BRUISE EASILY
___STOMACH PROBLEMS	___VENEREAL DISEASE	___EPILEPSY or SEIZURE
___GLAUCOMA	___HEPATITIS A, B OR C	___PSYCHIATRIC CARE
___STROKE	___PARKINSON'S DISEASE	___FAINTING OR DIZZINESS
	___SINUS TROUBLE	___OTHER, PLEASE EXPLAIN: _____

**HAVE YOU EVER TAKEN ANY MEDICATION FOR OSTEOPOROSIS? (SUCH AS: FOSAMAX, ACTONEL, BONIVA, ARELIA, ZOMETA OR OTHERS) \_\_\_ NO \_\_\_ YES WHICH MEDICATION? \_\_\_\_\_**

I hereby consent to the diagnostic procedures and treatment by this dentist and whomever he may designate as his assistants necessary for proper dental care. I also understand that I am responsible for payment in full of this account, regardless of insurance.

*Patient's signature* \_\_\_\_\_ *Date* \_\_\_\_\_

I certify that this information is complete and accurate

**For women only:** Are you taking birth control pills? Y / N Pregnant Y / N

Due Date: \_\_\_\_\_

Are you taking hormone therapy? Y / N

Have you reached menopause? Y / N