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: _____

Who may we thank for referring you? _____

Employer: _____Occupation: _____

Work Phone: ( ) _____Cell Phone: ( ) _____

Best number to call: ( ) _____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?_____

_____

Person to contact in case of emergency: _____Phone: ( )_____

Address: _____City:_____State:_____Zip: _____

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: _____

Pharmacy: _____Address: _____Phone: _____

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
___ARTIFICIAL HEART VALVE
___RHEUMATIC or SCARLET FEVER
___HEART MURMUR
___HEART FAILURE OR DISEASE
___HEART SURGERY
___JOINT REPLACEMENT (HIP, KNEE)
___SYNTHETIC VASCULAR GRAFT
___INFECTIOUS ENDOCARDITIS
___HEMODIALYSIS PATIENTS W/ FISTULA OR SHUNT NEURO-SURGICAL SHUNT
___STOMACH PROBLEMS
___GLAUCOMA
___STROKE
___SLEEP APNEA

___ASTHMA
___ANGINA PECTORIS
___HIGH BLOOD PRESSURE
___HIGH CHOLESTEROL
___THYROID DISEASE
___KIDNEY TROUBLE
___CANCER
___RADIATION OR CHEMOTHERAPY
___TUBERCULOSIS
___HIV POSITIVE
___VENEREAL DISEASE
___HEPATITIS A, B OR C
___PARKINSON'S DISEASE
___SINUS TROUBLE
___SNORING

___YELLOW JAUNDICE
___LIVER DISEASE
___ULCERS
___FEVER BLISTERS
___HEMOPHILIA
___BLOOD TRANSFUSION
___DRUG ADDICTION
___ARTHRITIS
___DIABETES
___BRUISE EASILY
___EPILEPSY or SEIZURE
___PSYCHIATRIC CARE
___FAINTING OR DIZZINESS
___OTHER, PLEASE EXPLAIN:
_____

HAVE YOU EVER TAKEN ANY MEDICATION FOR OSTEOPOROSIS? (SUCH AS: FOSAMAX, ACTONEL, BONIVA, AREDIA, 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