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: ( ) _____

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: _____

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

Print Form