

(Please Print)

Dr. _____
Pt# _____

Dr., Mr., Mrs., Ms. _____
First Middle Last

Date of Birth _____ SSN _____

Residence Address _____ City _____ State _____ Zip _____

Business Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-Mail Address _____

Employed By _____ Occupation _____

Single Married Divorced Widowed Separated Partner

Person Responsible for Account _____

Dental insurance coverage, if any _____

If insured: Self Spouse

If married, name of spouse _____

Employed by _____

This is required in order that the doctor may thoroughly diagnose your condition and it is, of course, confidential.

What is your present dental problem or area of concern? _____

Family Dentist's Name _____ Physician's name _____

Dentist's Address _____ Physician's address _____

Dentist's Phone _____ Physician's phone _____

Referred by _____

1. Are you currently under the care of a physician? _____ yes no

If yes, please explain _____

2. Are taking any medications at the present time? _____ yes no

If yes, what medications & dosage? _____

Any over the counter medications or herbs? _____

3. Are you allergic to any medications? _____ yes no

4. Do you take aspirin or anti-inflammatory medication products daily? _____ yes no

5. Do you take bisphosphonates for osteoporosis (e.g. Actonel, Fosamax, Aredia)? _____ yes no

6. Do you smoke? _____ How much? _____

7. Have you ever been treated for:

- Heart Trouble
- Mitral Valve Prolapse
- Rheumatic Fever
- Heart Murmur
- Open Heart Surgery
- Heart Attack
- Aortic Stenosis
- Stent Placement
- Excessive Bleeding
- Anemia
- Blood Borne Diseases
- High Cholesterol
- Abnormal Blood Pressure
- High Low
- Cancer
- Radiation Therapy for Cancer
- Arthritis
- Osteo
- Rheumatoid
- Artificial Shunts
- Prosthetic Joint Replacement
- Eye Problems
- Thyroid
- Renal Disease
- Tuberculosis
- Asthma
- Epilepsy
- Liver Disease
- Hepatitis
- A B C
- Herpes Simplex
- Aids
- HIV
- Diabetes
- Anorexia-Nervosa
- Bulimia
- Stomach Ulcers
- Allergies
- Sinusitis
- Osteopenia/Osteoporosis

8. Do you wear a pacemaker? _____ yes no

9. Have you ever had a local anesthetic? _____ yes no

10. Have you ever been warned against taking any drug or medicine? _____ yes no

11. Have you ever been told to premedicate before a dental visit? _____ yes no

12. Are you currently taking cortisone or steroids? _____ yes no

13. Have you ever fainted? _____ Do you have shortness of breath or chest pains? _____ yes no

14. Has your weight changed recently (other than self diet)? _____ yes no

15. Have you been on a medically restricted diet? _____ yes no

Date _____ Signed _____