

(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 \_\_\_\_\_ yes no

1. Are you currently under the care of a physician? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

2. Are taking any medications at the present time? \_\_\_\_\_

If yes, what medications & dosage? \_\_\_\_\_

Any over the counter medications or herbs? \_\_\_\_\_

3. Are you allergic to any medications? \_\_\_\_\_

4. Do you take aspirin or anti-inflammatory medication products daily? \_\_\_\_\_

5. Do you take bisphosphonates for osteoporosis (e.g. Actonel, Fosamax, Aredia)? \_\_\_\_\_

6. Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

7. Have you ever been treated for:

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

8. Do you wear a pacemaker? \_\_\_\_\_

9. Have you ever had a local anesthetic? \_\_\_\_\_

10. Have you ever been warned against taking any drug or medicine? \_\_\_\_\_

11. Have you ever been told to premedicate before a dental visit? \_\_\_\_\_

12. Are you currently taking cortisone or steroids? \_\_\_\_\_

13. Have you ever fainted? \_\_\_\_\_ Do you have shortness of breath or chest pains? \_\_\_\_\_

14. Has your weight changed recently (other than self diet)? \_\_\_\_\_

15. Have you been on a medically restricted diet? \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_