(***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. Actonol, Fosamax, Aredia)? _____	❑	❑
6. Do you smoke? _____ How much? _____		

7. Have you ever been treated for:

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