(***Please Print***)

Dr.__________
Pt#__________

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

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
- ❑ 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

	yes	no
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 ____