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Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Date of Birth: _____

Social Security Number: _____

Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Driver's License #: Email address:

Emergency Contact (Name, Telephone #, Relationship to Patient):

General Dentist: _____ **How often do you see your General Dentist for Dental Hygiene Maintenance? When was your last dental hygiene visit?**

MEDICAL HISTORY / ALLERGIES / MEDICATIONS

Please list any drug ALLERGIES or sensitivities:

Do you smoke or use tobacco products (cigarettes, cigars, e-cig, smokeless tobacco)? If yes, what form and how often used?

Do you drink alcohol? If YES, how many drinks per day? _____

Please list any drugs or medications you are currently taking:

Primary Care Physician (Name & Phone Number):

What was the date of your last complete physical? _____

Please list your height & weight: _____

MEDICAL CONDITIONS (Check all that apply)

- ☐ AIDS
- ☐ Allergies:Drug
- ☐ Allergies:Seasonal
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Blood Transfusion
- ☐ Breathing Disorders
- ☐ Bruises easily
- ☐ Cancer
- ☐ Chemotherapy/Radiation
- ☐ Chronic Cough
- ☐ Codeine Allergy
- ☐ Cold Sores
- ☐ Congenital Heart Disease
- ☐ Cortisone Medication
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spell
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Disease/Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery (stent,bypass)
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ History of Surgery
- ☐ HIV
- ☐ Kidney Trouble
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Low Blood Sugar
- ☐ Mitral Valve Prolapse
- ☐ Nervousness
- ☐ Organ Transplant
- ☐ Osteopenia/Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Penicillin Allergy
- ☐ PRE-MED
- ☐ Psychiatric Trt.
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Sleep Apnea/CPAP
- ☐ Smoker
- ☐ Special Diet
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Yellow Jaundice

Please list any other medical conditions:

_____

_____

Have you ever had any problems/complications with General Anesthesia or IV Sedation?

☐ None ☐ Nausea ☐ Allergy ☐ Other

If you have a History of Surgery, please list all major surgeries and the year they were done below.

_____

_____

If you have Artificial Joint(s), which joint(s) have you had replaced?

_____

_____

If you have diabetes, or a history of diabetes, which of the following types have you had? _____ What was your last A1C? _____ Date of last A1C? _____

_____

_____

If you have a History of Cancer, which type of cancer have you had? _____

Have you, or are you currently,undergoing any radiation treatment? (If so, when and where):

_____

_____

Do you take any of the following BLOOD THINNERS / ANTICOAGULANTS?

☐ Aspirin (81mg) ☐ Aspirin (325 mg) ☐ Coumadin/Warfarin ☐ Ibuprofen ☐ Plavix ☐ Xarelto

Name & Phone # of Prescribing Physician (for Blood Thinners/Anticoagulants): What was your most recent INR?

_____

_____

If you Pre-Medicate prior to your dental visits, list the antibiotic you have been prescribed and instructions:

_____

_____

Have you ever taken Bisphosphonates? (Example - Fosamax or Alendronate) _____ If so, what is the dosage?

_____

_____

Have you ever been told you have gum trouble or been treated for periodontal disease? If so, please list when you had it and what you had done.

_____

_____

Have you ever had Orthodontic treatment? If so, when did you this treatment and who was your orthodontist?

_____

_____

Do you ever clench your teeth? If so, under what circumstances?

_____

_____

Do you ever have swollen gums? _____ Bleeding gums? _____ Teeth sensitivity? _____

FOR WOMEN ONLY:

Are you pregnant? _____ If YES, what week of your pregnancy are you in? _____ Are you currently nursing? _____
Are you currently taking birth control pills? _____

The undersigned hereby authorizes the doctor or staff to take x-rays, study models, photography, or any diagnostic aids deemed appropriate to make a thorough diagnosis. All responsibility of payment for Dental Services provided in this office for myself or my dependent is totally mine. Payment is due and payable at the time of service unless a previous financial arrangement has been made.

☐ **By checking this box, I certify that all the above questions were answered truthfully and to the best of my knowledge with the understanding that they are necessary to provide quality care in a safe and efficient manner.**

Signature _____ **Date** _____

Physician

Signature _____ **Date** _____

Response Date: _____