

To whom may we thank for referring you to our office _____

Have we seen anyone in your family, if so, who? _____

Patient's Name: _____ **Date of Birth:** _____

Mailing Address: _____

City/State: _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

SS#: _____ **Email:** _____

Occupation: _____ **Employer:** _____

Spouse/Parent's Name: _____

Person Financially Responsible: _____

Person to Contact in Case of Emergency: _____

Phone #: _____ **Relation:** _____

Dental Insurance Company: _____ **Policy/Group#:** _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Subscriber's Relation to You: _____ **Subscriber's Employer:** _____

SS#/ Subscriber ID #: _____ **Ins. Phone #:** _____

MAIN DENTAL CONCERNS: _____

Last Dental visit: _____ **Reason:** _____

When was your last dental cleaning?: _____ **Last X-rays?:** _____

Are you aware of grinding or clenching?: _____ **Do you currently wear a Night Guard?** _____

Do you have pain in your jaw, neck, or face?: _____

Is there anything else you would like us to know about your dental health? _____

GENERAL PHYSICIAN _____ PHYSICIAN'S PHONE #: _____

DO YOU NEED TO BE PREMEDICATED DUE TO A MEDICAL CONDITION FOR YOUR DENTAL APPTS.?
FOR WHAT REASON _____

WHAT PREMEDICATION DO YOU TAKE?: _____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YRS.? _____ IF SO, PLEASE EXPLAIN _____

CHECK OR CIRCLE ALL THAT APPLY:

- | | | |
|--|---|--|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HEPATITIS A / B / C (please circle) |
| <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> AIDS / HIV |
| <input type="checkbox"/> ANGINA | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> HIGH CHOLESTEROL |
| Do you take Nitroglycerin? _____ | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> EMPHYSEMA LUNG DISEASE |
| <input type="checkbox"/> IRREGULAR HEART BEAT | <input type="checkbox"/> TUMOR HISTORY | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> STROKE Date: _____ | <input type="checkbox"/> CANCER / RADIATION | <input type="checkbox"/> COLD SORES |
| <input type="checkbox"/> HEART ATTACK | Date: _____ | <input type="checkbox"/> ASTHMA / DIFFICULTY BREATHING |
| <input type="checkbox"/> PROSTHETIC HEART VALVE | <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> RECENT WEIGHT CHANGE |
| <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> LIVER/KIDNEY DISEASE | <input type="checkbox"/> ANOREXIA/BULIMIA |
| <input type="checkbox"/> ARTIFICIAL JOINT | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> ANEMIA |
| ➢ HIP / KNEE / OTHER | <input type="checkbox"/> APHTHOUS ULCERS | <input type="checkbox"/> SINUS TROUBLE |
| Date: _____ | <input type="checkbox"/> LUPUS | <input type="checkbox"/> FREQUENT HEADACHES |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> STENT |
| ➢ TYPE I / TYPE II (circle) | <input type="checkbox"/> COSMETIC SURGERY | <input type="checkbox"/> HORMONE REPLACEMENT |
| Do you take Insulin? _____ | <input type="checkbox"/> SMOKER | <input type="checkbox"/> SLEEP APNEA |
| <input type="checkbox"/> MENTAL ILLNESS/ANXIETY/ DEPRESSION/ explain _____ | | |

<p>FOR WOMEN: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: _____ Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>ALLERGIES: <input type="checkbox"/> PENICILLIN <input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> LATEX <input type="checkbox"/> SULFA <input type="checkbox"/> EPINEPHRINE <input type="checkbox"/> DENTAL ANESTHETICS <input type="checkbox"/> METALS <input type="checkbox"/> OTHER: _____ _____</p>
--	---

OTHER MEDICAL CONDITIONS: _____

DO YOU TAKE ANY KIND OF BLOOD THINNER MEDS?: _____ IF SO, WHAT?: _____

DO YOU TAKE (or have you taken) BISPHOSPHONATE MEDS.?(for bone strength): _____

IF SO, WHAT?: _____ WHEN?: _____ FOR HOW LONG?: _____

HAVE YOU TAKEN ANY STEROID MEDS IN THE LAST 2 YEARS? _____ WHAT? _____

HOW LONG? _____

LIST CURRENT MEDICATIONS: _____

I the undersigned consent to examination and treatment agreed to be necessary. I realize the risks involved. I agree to assume responsibility for fees associated with these procedures.

PATIENT/GUARDIAN'S SIGNATURE

DATE