PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Name: _____ **Date:**_____

Male Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Preferred Name: _____ Birth Date:_____ Social Security #:_____-_____-_____

If Minor, Parent's Name: _____

Home phone#: _____-_____-_____ Work phone#: _____-_____-_____ Cell#: _____-_____-_____

Mailing address:_____

City: _____ State: _____ Zip: _____

Email:_____ @ _____

Physician Name: _____ Phone #: _____

Pharmacy Name:_____ Phone #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ ER contact: _____ ER contact #:_____

Whom may we thank for referring you to our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not Covered By Dental Insurance

Dental Insurance Co._____ Group number_____

Covered By Spouse's Insurance? ❑ Yes ❑ No

Spouse's Dental Insurance Company _____ Group number _____

Spouse's Birthday _____ Social Security Number _____

MEDICAL HEALTH HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Are you presently under the care of a physician?.....Yes or No
2. Have you ever had high blood pressure?.....Yes or No
3. Have you ever had an anesthetic(either local or general)?.....Yes or No
4. Have you had an allergic reaction to a local or general anesthetic?.....Yes or No
5. Are you allergic to Penicillin or Amoxicillin?.....Yes or No
6. Are you allergic to any other medications?.....Yes or No
   If yes, please list them here: _____
7. Are you allergic or sensitive to latex or metals?.....Yes or No
8. Please list if you are allergic to anything else: _____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Alcoholism
- ❑ Anemia or Blood Disorders
- ❑ Arthritis
- ❑ Artificial Joint (Year:_____)
- ❑ Asthma
- ❑ Blood transfusion(s)
- ❑ Cancer or tumor
- ❑ Chemotherapy
- ❑ Depression or Anxiety
- ❑ Diabetes(Avg Blood Sugar level:____ or HA1c:_____)
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Glaucoma
- ❑ Hayfever or Sinus Trouble
- ❑ Heart Ailment or Angina(chest pain)
- ❑ Heart Attack(Date of Occurrence:_____)
- ❑ Heart Murmur, Mitral Valve Prolapse, Heart Defect
- ❑ Heart Valve Replacement
- ❑ Hepatitis or any Other Liver Disease(s)
- ❑ Herpes or Cold Sores
- ❑ HIV+ or AIDS
- ❑ High or Low Blood Pressure
- ❑ Kidney Disease
- ❑ Lupus
- ❑ Migraines or Frequent Headaches
- ❑ Multiple Sclerosis
- ❑ Neurologic Condition(s)
- ❑ Pacemaker(Date of Placement:_____)
- ❑ Radiation Therapy
- ❑ Rheumatic Fever or Rheumatic Heart Disease
- ❑ Shingles
- ❑ Sjogren's Syndrome
- ❑ Stroke(Date of Occurrence:_____)
- ❑ Thyroid Problem
- ❑ Tuberculosis or Other Lung Problem(s)
- ❑ Ulcers or Any Other Stomach problems

Do you have any disease(s), condition(s), or problem(s) not listed above?

_____

_____

_____

_____

Are you taking any of the following medications and please specify?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics
- ❑ High blood pressure medicine
- ❑ Antidepressants, sedatives or tranquilizers
- ❑ Insulin, Metformin, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Pain Medications
- ❑ List any Medications:

Please list ALL medications you are currently taking:

_____

_____

_____

_____

_____

Have you taken or currently taking any Bisphosphonates(ie. Fosamax, Zometa, Reclast, Boniva, Aredia, Actonel, Skelid etc)?

❑ **Yes** ❑ **No**

If yes, please name the medication(s) and the duration:_____

Have you taken or are taking any additional medications such as Denosumab(Prolia or Xgevia)

❑ **Yes** ❑ **No**

Do you smoke or use chewing tobacco?

❑ **Yes** ❑ **No**

Women:

- ❑ May be pregnant

  Expected delivery date: _____
- ❑ Nursing
- ❑ Taking hormones or contraceptives

Signature of Patient (or Parent): _____ Date: _____