PATIENT INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City/State/Zip: _____

Home/Cell #: _____ Email Address: _____

Marital Status: _____ Occupation: _____ Sex: M F

Emergency Contact Name: _____ Contact #: _____

If you are completing this form for another person, what is your relationship to that person?

Name: _____ Relationship: _____

How did you hear about our office? _____

MEDICAL INFORMATION

Physician Name: _____ Pharmacy: _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Y	N	CONDITIONS
☐	☐	Artificial (Prosthetic) Heart Valve
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Autoimmune Disease
☐	☐	Bleeding Problems/Blood Thinners
☐	☐	Cardiovascular Disease
☐	☐	Cancer Chemotherapy or Radiation
☐	☐	Congenital Heart Defect
☐	☐	COVID-19
☐	☐	Cold Sores
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	G.E. Reflux
☐	☐	Glaucoma
☐	☐	HIV+/AIDS
☐	☐	Heart Disease
☐	☐	Hepatitis A, B, or C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney or Liver Disease
☐	☐	Mouth Sores
☐	☐	Osteoporosis

Y	N	CONDITIONS
☐	☐	Pacemaker/Heart Murmur
☐	☐	Previous Infective Endocarditis
☐	☐	Seizures
☐	☐	Sleep Disorder (CPAP)
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Other: _____

_____

Please provide more detail if any of the above conditions are marked yes:

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y	N		Y	N	
☐	☐	Acrylic	☐	☐	Iodine
☐	☐	Anesthetic	☐	☐	Latex
☐	☐	Aspirin	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Sulfa
☐	☐	Ibuprofen	☐	☐	Metals

☐ ☐ Other: _____

PLEASE ANSWER THE FOLLOWING:

Y	N	
☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
☐	☐	Have you ever taken an antiresorptive agent (like Fosamax, Boniva, Reclast, Prolia, Zometa, etc)?
☐	☐	Do you have any other disease, condition, or problem not listed on this page that you think we should know about? If yes, please explain:

_____

_____

☐ ☐ Do you use tobacco products?
If yes, please explain _____

_____

IF FEMALE PLEASE ANSWER THE FOLLOWING:

Y	N	
☐	☐	Are you pregnant? If yes, # of weeks: _____
☐	☐	Are you nursing?

Please list all prescribed and over the counter medications you currently take: _____

_____

_____

DENTAL INFORMATION

Reason for today's visit: _____

Date of last exam: _____

Date of last x-rays: _____

Are you currently experiencing any dental pain? ☐ Yes ☐ No
Have you had any periodontal (gum) treatment? ☐ Yes ☐ No
Do you brux or grind your teeth? ☐ Yes ☐ No
Are you dissatisfied with your smile? ☐ Yes ☐ No
Have you had any problems with previous dental treatment? ☐ Yes ☐ No
If yes to any of the above, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient (If under 18, Parent or Guardian is needed) Print Name Date