WELCOME

Please fill out this form as completely as possible. The better we communicate, the better we can care for you!

Today's Date _____ Name _____ I prefer to be called _____

DOB _____ SS# _____ Email Address _____

Address _____ City _____ Zip Code _____

Phone # _____ Cell # _____ Employer _____ Phone # _____

Emergency Contact Name and Phone # _____ Relation _____

Physician _____ Date of Last Physical Exam _____ Date of Last Dental Exam _____

I prefer to be contacted by: Phone Call ☐ Email ☐ Text Message ☐ Mail ☐ Other _____

We are currently contacting patients by phone but may use other contact methods in the future unless otherwise specified.

DO YOU, OR HAVE YOU EVER, HAD ANY OF THE FOLLOWING?

Breathing or respiratory problems	Y	N	OSTEOPOROSIS / BISPHOSPHONATES		
Asthma	Y	N	Treated for Osteoporosis - If yes,	Y	N
History of tuberculosis (TB)	Y	N	please list any IV or oral medications		
High Blood Pressure	Y	N	you currently or have ever taken.		
Low Blood Pressure	Y	N	_____		
Stroke	Y	N			
Heart Attack or Angina	Y	N	BLOOD THINNERS		
Heart Surgery	Y	N	Are you currently or have you ever taken	Y	N
Pacemaker	Y	N	blood thinners? If so, please list:		
Congenital Heart Defect	Y	N	_____		
Rheumatic Fever	Y	N			
Thyroid Problems	Y	N	PREMEDICATION CONSIDERATIONS		
Fibromyalgia	Y	N	Artificial Heart Valves	Y	N
Ulcer, GERD, Colitis	Y	N	Joint Replacement – If yes, what joint and	Y	N
Epilepsy/Seizures	Y	N	what year was it placed?		
Liver Disease	Y	N	_____		
Hepatitis A, B, or C	Y	N			
HIV positive	Y	N	ALLERGIES TO ANY OF THE FOLLOWING:		
Diabetes	Y	N	Latex	Y	N
Depression/Psychiatric Problems	Y	N	Penicillin	Y	N
Alcohol or Drug Abuse	Y	N	Codeine, Aspirin, or other pain meds	Y	N
Sleep Apnea	Y	N	Dental Anesthetics	Y	N
Cancer – If yes, what type of cancer?	Y	N	Other – If yes, please list _____	Y	N
_____			_____		
_____			FEMALE PATIENTS ONLY:		
Chemotherapy	Y	N	Pregnant or Nursing	Y	N
Radiation	Y	N	Using a prescribed method of birth control	Y	N

Have you ever had any serious medical conditions not listed on this form? _____

Have you been hospitalized in the past 5 years and for what? _____

Do you smoke or use tobacco of any form? _____ Are you interested in quitting? _____

Please list each prescription drug you are taking:

_____

_____

_____

The information I have given today is correct to the best of my knowledge. I understand this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature Date

Review of Medical History

1. _____ 2. _____

Signature Date Signature Date

3. _____ 4. _____

Signature Date Signature Date