PATIENT INFORMATION

Patient Name ______________________________ Preferred Name____________________ Gender ____
Last First MI

Birth Date ___________________ Social Security # ______________________ Driver's License ______________________

Address ____ City __________________ State _______ Zip Code________

Phone (H) ______________________ Cell _______________________ Email _____________________________________

Whom may we thank for referring you to our practice? ____

DENTAL HISTORY

Date of last dental visit: ______________________________

Brush and floss regularly?	Y	N
Bleeding from gums?	Y	N
Food catch between your teeth?	Y	N
Smoke/Vaping/E-Cig/Chew Tobacco/Marijuana?	Y	N

Reason for this visit: ________________________________

Tooth pain or discomfort?	Y	N
Clicking, popping or discomfort in jaw joints?	Y	N
Positive experience with past dental visits?	Y	N
Do you like your smile?	Y	N

Have you ever had any complications following dental treatment? Y N Please Explain: ______________________________________

Have you been admitted to a hospital or needed emergency care during the past two years? Y N Please explain: ___________________________

MEDICAL HISTORY

Have you ever taken / do you take bisphosphonates such as *Fosamax*®: Y N ______________________________________

Have you ever had any of the following below? Please indicate YES or NO

Y N	Allergy: Aspirin	Y N	Cancer	Y N	Head Injuries	Y N	Pacemaker
Y N	Allergy: Codeine	Y N	Chemotherapy / Radiation	Y N	Heart Disease	Y N	Pain in Jaw Joints
Y N	Allergy: Epinephrine	Y N	Chest Pain / Angina	Y N	Heart Murmur	Y N	Pregnancy Due:_______
Y N	Allergy: Ibuprofen	Y N	Cold Sores	Y N	Heart Surgery	Y N	Psychiatric Care
Y N	Allergy: Latex	Y N	Diabetes: Type 1 / Type 2	Y N	Hemophilia	Y N	Radiation Treatment
Y N	Allergy: Penicillin	Y N	Dizziness	Y N	Hepatitis A / B / C	Y N	Recent Weight Loss
Y N	Allergy: Sulfa Drugs	Y N	Drug Addiction	Y N	Herpes	Y N	Respiratory Problems
Y N	Allergy: Tetracycline	Y N	Emphysema	Y N	High Blood Pressure	Y N	Rheumatic Fever
Y N	Allergies: __________	Y N	Epilepsy or Seizures	Y N	Low Blood Pressure	Y N	Scarlet Fever
Y N	Alzheimer's Disease	Y N	Excessive Bleeding	Y N	Hypoglycemia	Y N	Shortness of Breath
Y N	Anemia	Y N	Excessive Thirst	Y N	HIV / AIDS	Y N	Stomach Problems
Y N	Arthritis / Rheumatism	Y N	Fainting	Y N	Jaundice	Y N	Stroke
Y N	Artificial Joints / Hips	Y N	Fever Blisters	Y N	Kidney Disease	Y N	Thyroid Disease
Y N	Artificial Heart Valve	Y N	Frequent Cough	Y N	Liver Disease	Y N	Tuberculosis
Y N	Asthma	Y N	Glaucoma	Y N	Lung Disease	Y N	Tumors
Y N	Blood Transfusion	Y N	Growths	Y N	Mental /Nervous Disorders	Y N	Ulcers
Y N	Bruise Easily	Y N	Hay Fever	Y N	Mitral Valve Problems	Y N	Venereal Disease

MEDICATIONS

Please list any current medications ____
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Physician ____ Phone ___________________________

Pharmacy ____ Phone ___________________________

Any health problems that need further clarification? Y N Explain: ______________________________________

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctors at the next appointment without fail.

X____ Date: ________________________

Signature of patient, parent or guardian

Reviewed by Dr:________________________ Date___________ **Blood Pressure** **Pulse**