

Patient Name: _____

Birth Date: _____

Date Created: _____

Whom may we thank for referring you to our office

- Website
- Saw Your Sign
- My Insurance Company
- Other: _____

Were you referred by a friend, please let us know Yes No If yes _____

Please list your Physician's name / Practice Name and Contact Phone Number below:

Are there aspects of our treatment that are difficult for you? If yes, how can we make it better? Yes No If yes _____

Have you ever been recently hospitalized? If yes, for what reason: Yes No If yes _____

Are you taking any medications, pills, or drugs? (Please list below)

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

FOR WOMEN ONLY

Women: Are you...

- Trying to get pregnant? Yes No
- Nursing? Yes No
- Taking oral contraceptives? Yes No

If Pregnant, Baby's due date _____

Are you allergic to any of the following?

- Aspirin
- Metal
- Dye/ coloring
- Penicillin
- Latex
- Foods
- Codeine
- Sulfa Drugs
- Other: _____
- Acrylic
- Local Anesthetics
- Other: _____

Do you have, or have you had, any of the following?

- | | | |
|--|--|---|
| ADHD <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No |
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Drug/Alcohol Addiction <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Migraines / Headaches <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Rheumatism <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Asthma <input type="radio"/> Yes <input type="radio"/> No |
| Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Autism Spectrum Disorder <input type="radio"/> Yes <input type="radio"/> No |
| Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | Autoimmune Disorder <input type="radio"/> Yes <input type="radio"/> No |
| Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Reflux/GERD <input type="radio"/> Yes <input type="radio"/> No | Blood Disease <input type="radio"/> Yes <input type="radio"/> No |
| Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No | Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No |
| Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Breathing Problems <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No |
| Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No | Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Hepatitis <input type="radio"/> Yes <input type="radio"/> No |
| Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No | Cancer <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs / Gout <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Dental Fear <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Depression <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No |
| Tobacco Use <input type="radio"/> Yes <input type="radio"/> No | Lyme Disease <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed Yes No If yes _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

X

Date: _____