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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Today's Date_____/_____/_____

PATIENT INFORMATION

Patient Name _____
First Middle Initial Last Nickname

Birthdate _____ ❑ Male ❑ Female ❑ Single ❑ Married

Phone #'s (_____)_____ (_____)_____ (_____)_____
Home Work Cell

Address _____
Street

_____
City State Zip Code

E-Mail Address _____

Responsible Party _____
Parent/Guardian

Whom may we thank for referring you? Dr. _____ / Friend _____

EMERGENCY INFORMATION

In case of emergency, who should we notify?: _____

Phone # (_____)_____ Second Phone # (_____)_____

CONFIDENTIAL MEDICAL HISTORY

Physician's Name _____ **Date of Last Visit** _____

PhoneNumber_____

Have you ever had the following? Please check (✔) those that apply:

- ☐ **Anemia**
- ☐ **Anxiety**
- ☐ **Arthritis/Rheumatism**
- ☐ **Artificial Joint/Hip/Knee**
- ☐ **Asthma/Hay Fever**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Chest Pain**
- ☐ **Diabetes**
  - **Last A1C** _____
- ☐ **Epilepsy**
- ☐ **Excessive Bleeding**
- ☐ **Fainting Tendency/Dizziness**
- ☐ **Glaucoma**
- ☐ **Growths**
- ☐ **Head/Facial Injury**
- ☐ **Heart Disease**
- ☐ **Heart Murmur/Mitral Valve**
- ☐ **Hemophilia**
- ☐ **Herpes**
- ☐ **HIV/AIDS**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Jaundice**
- ☐ **Hepatitis A**
- ☐ **Hepatitis B**
- ☐ **Hepatitis C**
- ☐ **Kidney Problems**
- ☐ **Liver Disease**
- ☐ **Low Blood Pressure**
- ☐ **Lung Disease**
- ☐ **Osteoporosis**
- ☐ **Pacemaker**
- ☐ **Psychiatric Problems**
- ☐ **Radiation Chemotherapy**
- ☐ **Respiratory Problems**
- ☐ **Rheumatic Fever**
- ☐ **Shortness of Breath**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Stroke**
- ☐ **Thyroid Disease**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **Venereal Disease**
- ☐ **Other Condition**

_____

_____

_____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin, Pondimin and Redux.
☐ Yes ☐ No

Have you ever taken any bisphosphonate type drugs which include Fosamax, Actonel, Boniva, Zometa and Aredia?
☐ Yes ☐ No If yes, for how long? _____Years _____Months

Are you currently... ☐ **pregnant ?** ☐ **nursing ?** ☐ **using birth control ?**

Do you smoke? ☐ Yes ☐ No **Do you use alcohol** on a daily basis? ☐ Yes ☐ No

Allergies, i.e., food, drugs, latex, local anesthetic? ☐ Yes ☐ No

If yes, please explain: _____

_____

CURRENT MEDICATIONS / UPDATED MEDICATIONS

Please list **ALL** prescription, over-the-counter (including **daily aspirin therapy**), and herbal medications you are currently taking. Also, please list the dosage, reason for each medication, and if the medication was prescribed by your physician.

Mo/Yr	Name of Medication	Reason	Prescribed by Your Physician	
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

CONFIDENTIAL DENTAL HISTORY

Reason for Today's Visit? _____

General Dentist: _____ **Date of Last Visit:**_____

Check (✔) if you have had problems with any of the following

- ☐ **Bad breath**
- ☐ **Bleeding gums**
- ☐ **Clicking or popping jaw**
- ☐ **Difficulty chewing**
- ☐ **Digestive problems**
- ☐ **Facial pain**
- ☐ **Food collection between teeth**
- ☐ **Gagging easily**
- ☐ **Grinding teeth**
- ☐ **Limited jaw opening**
- ☐ **Loose teeth or broken teeth**
- ☐ **Facial/jaw numbness**
- ☐ **Periodontal treatment**
- ☐ **Poorly fitting dental appliance**
- ☐ **Sensitivity**
- ☐ **Sores or growths in your mouth**
- ☐ **Teeth do not match properly**

Are you on any blood thinners? ☐ **Yes** ☐ **No**

If yes, last INR _____

Do you need antibiotic premedication prior to dental treatment? ☐ **Yes** ☐ **No** **Prescription:**_____

Do you have back or neck pain when sitting or leaning back? ☐ **Yes** ☐ **No**

DENTAL INSURANCE (PRIMARY)

Policy Holder Name _____
First Middle Initial Last

Relationship to Patient_____ Policy Holder Date of Birth _____/_____/_____

Policy Holder SS / ID # _____Group#_____

Policy Holder Employer/Company _____

or Self Insured: YES / NO Status: ❑ Full Time ❑ Part Time ❑ Retired

Insurance Co. _____ Phone #_____

DENTAL INSURANCE (SECONDARY)

Policy Holder Name _____
First Middle Initial Last

Relationship to Patient_____ Policy Holder Date of Birth _____/_____/_____

Policy Holder SS / ID # _____Group#_____

Policy Holder Employer/Company _____

or Self Insured: YES / NO Status: ❑ Full Time ❑ Part Time ❑ Retired

Insurance Co. _____ Phone #_____