



Welcome to our office! Thank you for taking the time to fill out this form completely. It will enable our team to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.

Name: _____

Address: _____

Today's Date: ___/___/___ Birthdate: ___/___/___ Home Phone Number: (___) _____

Email Address: _____

I'd like to receive email confirmations _____

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____
City State Zip

Phone #: (____) _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken bisphosphonate medication such as Fosomax, Zometa, Boniva, Actonel, Risedronate? Yes No

Are you taking any prescription or over-the-counter drugs? Yes No

If yes, please list each one: _____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Barbiturates

Y N Jewelry Y N Sulfa Drugs Y N Codeine

Y N Latex Y N Dental Anesthetics Y N Seasonal Hayfever

Y N Penicillin Y N Other

Please list additional drugs that cause allergic reactions: _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes, week #: _____ No

Are you nursing? Yes No

Have you experienced the following diseases or medical conditions?

- | | | |
|-----------------------------|-------------------------------|---------------------------|
| Y N Abnormal Bleeding | Y N Emphysema | Y N Liver Disease |
| Y N Alcohol/Drug Abuse | Y N Epilepsy/Seizures | Y N Mitral Valve Prolapse |
| Y N Anemia | Y N Fainting Spells | Y N Osteoporosis |
| Y N Arthritis/Rheumatoid | Y N Frequent/Severe Headaches | Y N Pacemaker |
| Y N Artificial Bones/Joints | Y N Glaucoma | Y N Persistent Cough |
| Y N Artificial Heart Valves | Y N Heart Attack | Y N Psychiatric Problems |
| Y N Asthma | Y N Heart Murmur | Y N Radiation Treatment |
| Y N Blood Transfusion | Y N Heart Surgery | Y N Sinus Problems |
| Y N Cancer | Y N Hepatitis Type | Y N Steroid Therapy |
| Y N Chemotherapy | Y N Herpes/Fever Blisters | Y N Stroke |
| Y N Colitis/Ulcers | Y N High/Low Blood Pressure | Y N Thyroid Problems |
| Y N Congenital Heart Defect | Y N HIV+/AIDS | Y N Tuberculosis (TB) |
| Y N Diabetes | Y N Infective Endocarditis | Y N Venereal Disease |
| Y N Difficulty Breathing | Y N Kidney Problems | |

Please list any hospitalizations or major surgeries in the last five years: _____

List any serious medical condition(s) that you have experienced: _____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of Patient, Parent or Guardian: _____ Date: _____