Patient Information

Patient Name_____Date of Birth_____

Mailing
Address_____City_____State____Zip_____

Home Phone_____Work Phone_____CELL #:_____

Email_____Marital status___Spouse_____

Would you like to receive text messaging from our office (please circle) Yes / No

Cell number_____

Physican Name_____Phone_____Last Exam_____

Preferred
Pharmacy_____Phone_____

Person Financially Responsible_____Employer_____

Dental Insurance? PLEASE PROVIDE INSURANCE CARD AT THIS APPOINTMENT

Medical History

Do you PREMEDICATE WITH AN ANTIBIOTIC for dental appointments due to any of the following? (please circle) Heart Surgery Joint replacement Other_____

Do you or have you ever taken medication for BONE LOSS OR OSTEOPOROSIS? YES NO
What medication did you take?_____
Please circle:

Y N	Are you pregnant?	Y N	Colitis
Y N	Are you nursing?	Y N	HIV/ AIDS/ other STD
Y N	Do you take birth control?	Y N	Cosmetic Surgery
Y N	Do you smoke or use tobacco/vape? YEARS QUIT?_____		
Y N	Diabetes		
Y N	Abnormal Bleeding	Y N	Breathing Problems
Y N	Do you take blood thinners?_____	Y N	Drug Abuse
Y N	Alcohol Consumption? Per week_____	Y N	Emphysema
Y N	Seasonal allergies	Y N	Epilepsy
Y N	Anemia	Y N	Fainting
Y N	Angina Pectoris	Y N	Cold or Canker Sores
Y N	Arthritis	Y N	Headaches
Y N	Artificial joint	Y N	Glaucoma
Y N	Heart valve replacement	Y N	Jaundice
Y N	Asthma	Y N	Stents

GENDER_____ HEIGHT_____ WEIGHT_____

TURN OVER AND CONTINUE FILLING OUT THE OTHER SIDE

Y N Blood Transfusion? Date_____
Y N Cancer
Y N Chemotherapy/Radiation/other cancer treatment
Y N High Blood Pressure

Y N Low Blood Pressure
Y N Kidney Problems
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Pace Maker
Y N Pneumonia/Lung Problem
Y N Psychiatric Problems
Y N Radiation Therapy
Y N Rheumatic Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems or Surgery
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers
Y N Heart Attack
Y N Heart Surgery/Cardiac Disorder
Y N Heart Defect
Y N Hemophilia
Y N Hepatitis/type_____

PLEASE LIST ALLERGIES:

_____
_____
_____
_____

PLEASE LIST ALL <u>MEDICATIONS</u> YOU TAKE INCLUDING VITAMINS/SUPPLEMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ONGOING MEDICAL/SYSTEMIC CONCERN_____
How do you consider your physical tolerance?_____
How do you consider your emotional health?_____

Do you wish to retain your natural dentition if possible?_____

SIGNATURE_____DATE_____

DOCTOR NOTES: (OFFICE ONLY) TO INCLUDE RELEVANT FAMILY MEDICAL HISTORY AND

GENERAL HEALTH AND APPERANCE OF PATIENT: