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FOR OFFICE USE ONLY
- ❑ In computer
- ❑ NP letter
- ❑ Thank you referral letter
- ❑ Scanned

PATIENT INFORMATION

Patient Name ______________________________ Date ____________
LAST, FIRST MI (PREFERRED NAME)

Birth date ____________ Gender: ❑Male ❑Female Family Status: ❑Married ❑Single ❑Divorced ❑Widow

Social Security #____________________ E-mail address ____________________

Address ______________________________
STREET APARTMENT #
____

Home Phone ____________ Work/Ext. ____________ Cell ____________

May we leave a treatment message? ❑Yes ❑No What type of message may we leave? ❑Voice message ❑Text message

Where may we leave treatment messages? ❑Home phone ❑Cell phone ❑Work phone

Preferred method to notify you of your appointments ❑ Home ❑ Work ❑ Cell ❑ E-Mail ❑ Text Message

Preferred appointment times ❑ Morning ❑ Afternoon ❑ Evening ❑ Any Time Preferred appt. days ❑M ❑ T ❑W ❑Th ❑F

Employer Name ____________________ Occupation ____________

Address ______________________________
STREET CITY STATE ZIP

Emergency contact: ______________________________
NAME / RELATIONSHIP PHONE

MEDICAL HISTORY

(Check DK if you don't know the answer to the question)

	YES	NO	DK
DO YOU WEAR CONTACT LENSES?	❑	❑	❑
JOINT REPLACEMENT. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? (please circle) If yes, have you had any complications? ____________	❑	❑	❑
Are you scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑
Since 2001, were you treated, or presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	❑	❑	❑

	YES	NO	DK
Do you use controlled substances (drugs)?	❑	❑	❑
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? (circle one) VERY / SOMEWHAT / NOT INTERESTED	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑
If yes how much alcohol did you drink in the last 24 hours? ____________			
If yes, how much do you typically drink in a week? ____________			
WOMEN ONLY. Are you:			
Pregnant? If yes, number of weeks ____________			
Taking birth control pills or hormonal replacement?	❑	❑	❑
Are you nursing?			

ALLERGIES. Please check and list reactions for any allergies you may have:

	YES	NO	DK
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Other: ____________	❑	❑	❑

	YES	NO	DK
Metals	❑	❑	❑
Latex (rubber)	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal	❑	❑	❑
Animals	❑	❑	❑
Food	❑	❑	❑
Other ____________	❑	❑	❑

Have you ever had any of the following?
Please check those that apply:

	YES	NO	DK
Artificial (prosthetic) heart valve	❑	❑	❑
Previous infective endocarditis	❑	❑	❑
Damaged valves in transplanted heart	❑	❑	❑

	YES	NO	DK
Congenital heart disease (CHD)	❑	❑	❑
Unrepaired, cyanotic CHD	❑	❑	❑
Repaired (completely) in last 6 months	❑	❑	❑
Repaired CHD with residual defects	❑	❑	❑

Except for the conditions listed above antibiotic prophylaxis is no longer recommended for any other form of CHD.

PLEASE CONTINUE ON BACK OF THIS PAGE

Please check any of the following that may apply to you:

	YES	NO	DK
Abnormal bleeding	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Asthma	❑	❑	❑
Autoimmune	❑	❑	❑
Blood transfusion. If yes, date:________________	❑	❑	❑
Cancer/chemotherapy/Radiation Treatment	❑	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑	❑

____Angina
____Arteriosclerosis
____Artificial heart valves
____Congenital heart defects
____Congestive heart failure
____Coronary artery disease
____Damaged heart valves
____Heart attack
____ Heart murmur
____ High blood pressure
____ Low blood pressure
____ Mitral valve prolapsed
____ Pacemaker
____ Rheumatic heart disease/Rheumatic fever

	YES	NO	DK
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Diabetes Type I (insulin dependent), or Type II	❑	❑	❑
Eating disorder. If yes, specify:________________	❑	❑	❑
Epilepsy	❑	❑	❑
Excessive bleeding	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
GE Reflux /persistent heartburn	❑	❑	❑
Glaucoma	❑	❑	❑
Growths/tumors	❑	❑	❑
Hemophilia	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Recurrent infections. If yes, indicate type ________________	❑	❑	❑
Kidney disease	❑	❑	❑
Mental health disorders. If yes, specify ________________	❑	❑	❑
Malnutrition	❑	❑	❑
Neurological disorders. If yes, specify ________________	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Recurrent infection. If yes, specify ________________	❑	❑	❑
Respiratory problems, If yes, specify below:	❑	❑	❑
___Emphysema ___Bronchitis, etc.	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Sinus trouble	❑	❑	❑
Sleep disorder	❑	❑	❑
Sores or ulcers in the mouth	❑	❑	❑
Stroke	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Tuberculosis	❑	❑	❑
Thyroid problems	❑	❑	❑
Ulcers	❑	❑	❑
Do you have any disease not listed that I should know about?	❑	❑	❑

Please explain ________________

Please list all prescribed and over-the-counter medications you take:________________

____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑Yes ❑No
If yes, please list ________________

____
Name of physician or dentist who made the recommendation Phone number

____
Name of primary care physician Phone number

DENTAL HISTORY

	YES	NO
Are you having dental discomfort today?	❑	❑
Are you missing any teeth other than wisdom teeth or orthodontic extractions?	❑	❑
Have missing teeth been replaced?	❑	❑
Do your gums bleed when you brush or floss?	❑	❑
Are you concerned about gum disease?	❑	❑
Do you have any concerns about the appearance of your teeth?	❑	❑
Does it hurt to bite or chew?	❑	❑
Do you clench or grind your teeth?	❑	❑
How would you describe your dental health? ❑Excellent ❑Good ❑Fair ❑Poor		
Have you ever had a problem with:		
Local anesthetic?	❑	❑
Previous dental treatment?	❑	❑
Nitrous oxide sedation?	❑	❑
Cleaning or periodontal therapy?	❑	❑
Do you want to become a regular continuing care patient in our practice?	❑	❑

Do you take antibiotics for dental appointments? ❑Yes ❑No If yes, what antibiotic do you take? ________________

When was your last cleaning or periodontal therapy? ________________

What factors are most important for your satisfaction with our office? ________________

Do you have any additional concerns or comments?________________

CONSENT FOR TREATMENT

NOTE: BOTH Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form

____
Signature of Patient / Legal Guardian Date