Name _____ Home Phone (___) _____
Last First M

Address _____ City _____ State _____ Zip Code _____

Cell Phone (___) _____ Work Phone (___) _____ E-mail _____

Employer _____ Social Security No. _____ Date of Birth ____/____/____ Sex ☐ M ☐ F

Who were you referred by: _____ Has a family member ever been a patient of our practice? ☐ Yes ☐ No

Emergency Contact _____ Relationship _____ Phone (____) _____

If you are completing this form for another person, what is your relationship to that person? _____

Medical Information

Physician _____
Name Phone Address City/State/Zip

_____

Pharmacy _____
Name Phone Address City/State/Zip

Yes No _____

☐ ☐ Has there been any change in your general health within the last year?

☐ ☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, why? _____

Please list all prescription and non-prescription medications, herbal supplements you are taking or have recently taken.

_____ _____

_____ _____

_____ _____

_____ _____

Have you had a serious/difficult problem associated with any previous dental treatment? if so, explain. _____

_____

Have you ever been diagnosed or treated for oral cancer? ☐ Yes ☐ No If yes, explain. _____

Do you take or have ever taken Bisphosphonate medications for osteoporosis or bone density? ☐ Yes ☐ No

Do you take any blood thinners (examples of some Aspirin, Coumadin, Plavix) or have abnormal bleeding? ☐ Yes ☐ No If yes, list medication _____

Do you have TMD (Jaw Joint) Disorder? ☐ Yes ☐ No

Yes No

☐ ☐ Do you drink alcoholic beverages? ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially

☐ ☐ Are you alcohol and/or drug dependent? If so have you received treatment? ☐ Yes ☐ No

☐ ☐ Do you use drugs or other substances for recreational purposes? Please list. _____

☐ ☐ Do you use tobacco (smoking, snuff, chew)? If so, frequency of use. _____

Allergies Are you allergic to or have you had a reaction to:

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Other Antibiotics	☐	☐	Metals
☐	☐	Penicillin/Amoxicillin	☐	☐	Local Anesthetics	☐	☐	Iodine
☐	☐	Erythromycin	☐	☐	Sedatives	☐	☐	Hay Fever/Seasonal
☐	☐	Clindamycin	☐	☐	Codeine/Other Narcotics	☐	☐	Food (Specify) _____
☐	☐	Sulfa drugs	☐	☐	Latex	☐	☐	Eggs/Yolks

To yes responses, specify type of reaction _____

Yes No

☐ ☐ Do you have an artificial heart valve or mitral valve prolapse or heart murmur?

☐ ☐ Have you had an orthopedic total joint (hip, knee, elbow) replacement? If so, when was this operation done? _____

☐ ☐ Has a physician recommended that you take antibiotics prior to your dental treatment? If so, what

Antibiotic and dose? _____

Name of physician _____ Phone _____

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