PLEASE PRINT Today's Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ M___ F___ Home Phone_____
(last, first, middle) (Nickname)

Email _____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

Soc Sec # _____ Patient's Employer_____ Work Phone_____

Other Family Members Seen_____ Whom May We Thank for Referring You_____

Person to Contact in Case of Emergency_____ Phone_____

INSURANCE INFORMATION

Name of Subscriber_____ Relationship to patient_____

Birthdate_____ Social Security #_____ Name of Employer_____

Insurance Company_____ Group #_____

PATIENT MEDICAL HISTORY

The more we know about your past and present overall health, the better care we are able to give you. Please complete all the questions below. All responses are held in professional confidence.

Name of Physician_____ Phone Number_____

1. Please list any changes in your general health in the last year along with all treatment received from your physician or other medical personnel in the last 3 years EXCEPT routine examinations or visits for minor colds -- indicate whether hospitalization was required for any of these conditions including any surgeries:

_____

2. List any medications, non-prescription drugs or herbal supplements which you are currently taking:_____

_____

3. List any items to which you are allergic (i.e. Medications,Latex, Metals, Jewelry, other):_____

4. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes:_____

5. Do you have a bleeding problem/ disorder or take blood thinners? If yes:_____

6. Do you snore or wake up tired in the morning? Yes_____No_____

7. Do you have headaches, neck pain or jaw tightness/pain? Yes____No____

8. Circle any of the following which you have or have had in the past:

Congenital Heart Problems	Seizures/Epilepsy	Excessive Bleeding/Easily Bruises	Osteoporosis
Chest pain,angina	Shortness of Breath	Anemia	Osteoporosis Meds (Foasmax,
Heart attack	Tuberculosis	Fainting	Actonel, Boniva, etc.)
Heart surgery (valve, stent, ablation)	Asthma/ other Lung Disease	Cancer/Tumor	HIV/AIDS
Pacemaker/Defibrillator	Liver Disease (Hepatitis, etc.)	Chemo/Radiation Therapy	Autoimmune Disorder
High/Low Blood Pressure	Kidney Disease	Leukemia	Immunosuppression
Heart murmur	Glandular Problems	Arthritis	Depression/Bipolar
Rheumatic Fever	Thyroid Disease	Joint Replacement	Dental Apprehension
Neurological Disorders	Diabetes	Premed	Drug/Alcohol Dependency
Stroke	Stomach Problems (Ulcer, IBS)	Sleep Apnea	Anxiety

Any conditions or diseases not list above? If yes:_____

9. List any Surgeries_____

10. Have you had head and neck radiation? Yes ____ No ____

11. Female patients: Are you pregnant or breast feeding at the present time? Yes ____ No ____

12. Do you use or have a history of use of tobacco products, alcohol, or recreational drugs? No ____ If Yes what kind _____

_____

13. Have you ever been told you have gum disease? Yes ____ No ____

14. Is there anything about your smile you would like to change?

_____

_____ _____
Patient's Signature (If child, parent's) Dentist's Signature