

Patient Name _____	Date of Birth _____
Home Address _____	Home Phone _____
_____	Cell Phone _____
E-Mail _____	Work Phone _____
Employer _____	SSN# _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Have you ever taken Fosamax, Boniva, Actonel or any			
Other medications containing bisphosphonates?	Yes	No	
Women: Are you			
Pregnant/Trying to get pregnant?	Yes	No	Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?							
Aspirin	Penicillin	Codeine	Acrylic	Metal	Latex	Local Anesthetics	sulfa drugs
Other If yes, please explain: _____							

Do you have, or have you had, any of the following?						High Cholesterol	Yes	No
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No
						Renal Dialysis	Yes	No
						Rheumatic Fever	Yes	No
						Rheumatism	Yes	No
						Scarlet Fever	Yes	No
						Shingles	Yes	No
						Sickle Cell Disease	Yes	No
						Sinus Trouble	Yes	No
						Spina Bifida	Yes	No
						Stomach/Intestinal Disease	Yes	No
						Stroke	Yes	No
						Swelling of Limbs	Yes	No
						Thyroid Disease	Yes	No
						Tonsillitis	Yes	No
						Tuberculosis	Yes	No
						Tumors or Growths	Yes	No
						Ulcers	Yes	No
						Venereal Disease	Yes	No
						Yellow Jaundice	Yes	No
						Human Papilloma Virus	Yes	No
Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____								

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

We require 48 hours (two business days) advance notice to cancel or change your appointment to avoid \$75 broken appointment fee per half hour of scheduled appointment time.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____