( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms.

PATIENT NAME	EMAIL ADDRESS	Cell Phone & Home Phone Cell ( ) Home ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status □ Single □Married □Divorced □ Separated	Gender:	Drivers License & State

Primary Insurance Company ______________________ Subscriber ________________ Member ID____________________ Group #__________

Secondary Insurance Company ____________________ Subscriber ________________ Member ID____________________ Group #__________

RESPONSIBLE PARTY

NAME	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status □ Single □Married □Divorced □ Separated	Relationship to Patient	Drivers License & State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Spouses Occupation	Spouse's Work Phone ( )
Spouse's Employer		
Spouse's Business Address	City	State Zip

How did you hear about our Office? (Check only one)

Where did you find the Phone Number to this office?

□ Referred □Yellow Pages □ Relative □ Insurance Plan □ Web Page □ Sign by Building □ Other ______________________________________

PATIENTS DENTAL HEALTH

Patient Name: ___________________________________

Why have you come in to see us today? (e.g.: pain, checkup, etc.) ____

Previous Dentist _______________________________________ Last Visit ________________________ Date of Last Cleaning_______________

Reasons for changing Dentists: ____

What problems have you had with past dental treatment? ____

Are you nervous about seeing a dentist? □ Yes □ No If yes, please tell us why: ____

How often do you brush? ___________________________________ Do you floss? □ Yes □ No How Often? ____________________________

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I have had a facial or jaw injury.
Y N I want straight teeth.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I avoid brushing part of my mouth due to pain.
Y N I want my teeth whiter.

What are your dental priorities? ____
(e.g.: appearance, dental health, financial consideration, etc.)

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. **Yes No ?**

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto), dabigatran (Pradaxa), clopidogrel (Plavix), heparin or aspirin)?.................... □ □ □

If Yes, what medication are you taking? ______________________________

Are you taking any medication to treat **osteoporosis** or Paget's disease?.................... □ □ □

Some commonly-prescribed drugs include alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva) zolendronate (Reclast) and denosumab (Prolia). ... □ □ □

If Yes, what medication are you taking? ______________________________

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .... □ □ □

Some commonly-prescribed drugs include denosumab (Xgeva), pamidronate (Aredia), or zolendronate (Zometa).

If Yes, what medication are you taking? ______________________ How may years have you been taking it? __________

Are you taking **hormonal replacements**? .... □ □ □

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? .... □ □ □

Do you use **Vaping products**? .... □ □ □

How many **alcoholic beverages** do you have per week? _______________

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? .... □ □ □

If yes, what substances? ______________ If yes, how often is your use? □ Daily □ Several times per week □ Weekly □ Occasionally

Was the substance prescribed by a doctor? □ Yes □ No If yes, for what reason(s)? ______________________

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements? ....** □ □ □

If yes, please list them here and include information about how much and how often you use each one. ______________________

____

____

____

____

____

WOMAN ONLY: Are you:

Taking **birth control pills? ....** □ □ □

Pregnant? If yes, number of weeks: ____________ .... □ □ □

Nursing? If yes, number of weeks: ____________ .... □ □ □

PATIENT MEDICAL HISTORY

I consider my health to be (*please check one*) □ Excellent □ Good □ Fair □ Poor

Do you or have you had any of the following? *(please circle Y for yes or N for no*)

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Artificial heart valves
7. Y N A history of infective endocarditis
8. Y N Certain specific, serious congenital (present from birth) heart conditions
9. Y N High Blood Pressure
10. Y N Low Blood Pressure
11. Y N Anemia
12. Y N Tuberculosis or Lung Disease
13. Y N Asthma
14. Y N Pacemaker
15. Y N Epilepsy/Seizures
16. Y N Excessive Bleeding
17. Y N Hepatitis Type _____
18. Y N Diabetes
19. Y N ARC or AIDS
20. Y N Shunts
21. Y N Malignancies
22. Y N Radiation Therapy
23. Y N Implants/Artificial Joints: □ Hip □ Knee □ Other
24. Y N Allergy to Penicillin
25. Y N Allergy to Other Antibiotics: ______________________
26. Y N Allergy to Local Anesthetics: ______________________
27. Y N Allergy to Other: ______________________________
28. Y N Do you have any other medical problem or medical history NOT listed on this form? ______________________
29. Y N I have had major surgery: Year _________ Type of Operation: ______________________

Name of General Physician: ______________________ Address ______________________ Phone _______________

In the event of an emergency please contact:

Name ______________________ Relationship ______________________ Phone ______________________

Name ______________________ Relationship ______________________ Phone ______________________

CONSENT

* I have answered all Health Questions to the best of my knowledge __________ *Initial* ***Doctor's Initials __________ Reviewed Health History***

After explanation by the doctor, I hereby authorize the performance of dental services upon the below named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

____

Print Patients Name Date

____

Signature of Patient or Guardian Date Relationship to Patient