Patient Name: _____ Sex: M / F Marital Status: S M D W Email: _____

Patient D.O.B.:_____ Age: _____ Driver's License #:_____ Mobile #:_____ Home #: _____

Address: _____ City: _____ State: ____ Zip: _____ SSN:_____

Employer: _____ Occupation: _____ Work #: _____

Spouse / Parent / Guardian Name: _____ Parent / Guardian D.O.B.: _____ Phone #: _____

Primary Dental Insurance: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: _____ Insured Birth Date: _____ Employer: _____

Secondary Dental Insurance: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: _____ Insured Birth Date: _____ Employer:_____

Referring Dentist:_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

YES NO Heart Attack / Stroke
YES NO Artificial Joints / Limbs DATE PLACED: _____
YES NO Heart Murmur / Rheumatic Fever
YES NO Heart Surgery / Pacemaker DATE: _____
YES NO Congenital Heart Disorder / Mitral Valve Prolapse
YES NO Anemia
YES NO High / Low Blood Pressure
YES NO High / Low Cholesterol
YES NO Severe Headaches / Migraines
YES NO Asthma / Breathing Problem / Emphysema / COPD
YES NO Epilepsy / Seizures / Fainting Spells
YES NO TMJ / (Jaw Joint) Problems / Clench or Grind
YES NO Daily Aspirin or Blood Thinner
YES NO Dental Anxiety

YES NO Hemophilia / Abnormal Bleeding
YES NO Blood Transfusion
YES NO Cancer / Chemotherapy / Radiation
YES NO HIV+ / AIDS
YES NO Tuberculosis (TB)
YES NO Hepatitis Circle One A B C
YES NO Shingles
YES NO Kidney Problems
YES NO Sinus Problems / Seasonal Allergies
YES NO Diabetes
YES NO Arthritis / Joint Disease
YES NO Thyroid Disease
YES NO Drug / Alcohol Abuse
YES NO Osteoporosis / Osteopenia
YES NO Have you ever taken a Bisphosphonate
For Osteoporosis such as: Boniva?
Fosamax, Actonel, Skelid, Zometa?
How long have you taken it? _____
Or been off of it? _____

Are you required to take Antibiotics / Premed prior to
Dental treatment due to a heart issue or
Joint / valve replacement?
If YES – For What? _____

Any other health issue not listed above: _____ **Pregnant Week #:** _____

ARE YOU ALERGIC TO THE FOLLOWING: PLEASE CIRCLE YES OR NO

YES NO Latex
YES NO Dental Anesthetic
YES NO Penicillin
YES NO Codeine
YES NO Aspirin
YES NO Sulfa
Any other allergies: _____

LIST OR PROVIDE A LIST OF ALL CURRENT MEDICATIONS

_____

_____

_____

_____

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 health. It is my responsibility to inform the office staff of any medical changes.

Signature:_____ **Date:** _____