

PATIENT INFORMATION



Patient Name: _____ Date: _____
 Date of Birth: _____ Social Security #: _____
 Address: _____ City/State/Zip: _____
 Home/Cell #: _____ Email Address: _____
 Marital Status: _____ Occupation: _____ Sex: M F
 Emergency Contact Name: _____ Contact #: _____

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

Name: _____ Relationship: _____

How did you hear about our office? _____

MEDICAL INFORMATION

Physician Name: _____ Pharmacy: _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Y	N	CONDITIONS	Y	N	CONDITIONS			
☐	☐	Artificial (Prosthetic) Heart Valve	☐	☐	Pacemaker/Heart Murmur			
☐	☐	Arthritis	☐	☐	Previous Infective Endocarditis			
☐	☐	Asthma	☐	☐	Seizures			
☐	☐	Autoimmune Disease	☐	☐	Sleep Disorder (CPAP)			
☐	☐	Bleeding Problems/Blood Thinners	☐	☐	Stroke			
☐	☐	Cardiovascular Disease	☐	☐	Tuberculosis			
☐	☐	Cancer Chemotherapy or Radiation	☐	☐	Other: _____			
☐	☐	Congenital Heart Defect	Please provide more detail if any of the above conditions are marked yes: _____					
☐	☐	COVID-19						
☐	☐	Cold Sores	ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?					
☐	☐	Diabetes						
☐	☐	Epilepsy	Y	N	Y	N		
☐	☐	G.E. Reflux	☐	☐	Acrylic	☐	☐	Iodine
☐	☐	Glaucoma	☐	☐	Anesthetic	☐	☐	Latex
☐	☐	HIV+/AIDS	☐	☐	Aspirin	☐	☐	Penicillin
☐	☐	Heart Disease	☐	☐	Codeine	☐	☐	Sulfa
☐	☐	Hepatitis A, B, or C	☐	☐	Ibuprofen	☐	☐	Metals
☐	☐	High Blood Pressure	☐	☐	Other: _____			
☐	☐	Joint Replacement	PLEASE ANSWER THE FOLLOWING: Y N ☐ ☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ Have you ever taken an antiresorptive agent (like Fosamax, Boniva, Reclast, Prolia, Zometa, etc)? ☐ ☐ Do you have any other disease, condition, or problem not listed on this page that you think we should know about? If yes, please explain: _____ ☐ ☐ Do you use tobacco products? If yes, please explain _____					
☐	☐	Kidney or Liver Disease						
☐	☐	Mouth Sores	IF FEMALE PLEASE ANSWER THE FOLLOWING: Y N ☐ ☐ Are you pregnant? If yes, # of weeks: _____ ☐ ☐ Are you nursing?					
☐	☐	Osteoporosis						

Please list all prescribed and over the counter medications you currently take: _____

DENTAL INFORMATION

Reason for today's visit: _____

Date of last exam: _____

Date of last x-rays: _____

Are you currently experiencing any dental pain? ☐ Yes ☐ No

Have you had any periodontal (gum) treatment? ☐ Yes ☐ No

Do you brux or grind your teeth? ☐ Yes ☐ No

Are you dissatisfied with your smile? ☐ Yes ☐ No

Have you had any problems with previous dental treatment? ☐ Yes ☐ No

If yes to any of the above, please explain: _____

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 dental office of any changes in medical status.

Signature of Patient (If under 18, Parent or Guardian is needed)

Print Name

Date