Personal Information

Full Name _____ Today's Date _____
Mr. Mrs. Ms. Rev. Dr.

I prefer to be addressed as _____ Birthdate _____

Address _____ Home Phone _____

_____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

E-mail address _____

Preferred contact ❑E-mail ❑Home Phone ❑Work Phone ❑Cell Phone Best time to call _____

Employer _____ Occupation _____

Spouse / Partner _____ Cell Phone _____

Additional Emergency contact _____Phone _____

Last dental visit _____ with Dr. _____

Whom may we thank for referring you to our practice?_____

Physician _____ Phone _____

How would you assess your general health? ____Good ____Fair ____Poor Last physical _____

Have you been hospitalized in the last 3 years? _____Yes _____No_____

List medications you take - please include prescription and over-the-counter (Continue on other side if needed)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had an ALLERGIC reaction? _____No _____Yes If Yes please list allergies: Include medications, substances, foods, etc.

_____ _____ _____

_____ _____ _____

Medical Conditions

Check if you now have or have you ever had the following:

___ Acid Reflux (GERD)
___ AFIB/Atrial Fibrillation
___ Angina Pectoris/Chest Pains
___ Anxiety/Depression
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Atherosclerosis
___ Autoimmune Disorder
___ Bleeding Disorder
___ Blood Transfusion
___ Cancer
___ Chemotherapy
___ Chronic Fatigue
___ Chronic Pain
___ COPD
___ Coronary Heart Disease
___ Diabetes – Type 1
___ Diabetes – Type 2
___ Dizziness/Fainting
___ Eating Disorder/Malnutrition
___ Emphysema
___ High Cholesterol
___ Epilepsy/Seizure
___ Excessive Daytime Sleepiness
___ Fibromyalgia
___ Gastrointestinal Disease
___ Glaucoma
___ Gout
___ Heart Attack
___ Heart Murmur
___ Hepatitis
___ Liver Disease
___ High Blood Pressure
___ HIV/AIDS
___ Insomnia
___ Kidney Disease/Failure
___ Liver Disease
___ Meniere's Disease
___ Mitral Valve Prolapse
___ Anemia
___ Muscular Dystrophy
___ Neuralgia
___ Osteoarthritis
___ Osteoporosis
___ Radiation Treatment
___ Rheumatic Fever
___ Rheumatoid Arthritis
___ Sexually Transmitted Disease
___ Sinus Problems
___ Sleep Apnea
___ Snoring
___ Stroke
___ Thyroid Disease
___ Transplant
___ Tuberculosis
___Tumors
___Urinary Disorders
___Mental Health Disorder
___ Migraines/Severe Headaches
___Multiple Sclerosis

Other: _____

Do you or have you ever taken bisphosphonate drugs? (Drugs for bone density, Osteoporosis, etc.) ___YES___NO

Have you ever smoked? ____Yes ____No I Quit When? _____ Yes - Still do How much? _____

(WOMEN) Are you taking birth control pills? ___No ___Yes
Are you pregnant? ___No ___Yes - Due date _____
Are you currently nursing? ___No ___Yes

The information present on these pages is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. Upon my verbal agreement following discussion of recommended treatment, I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I have read the above: **Signature** _____**Date** _____

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