Today's Date _____

PATIENT INFORMATION

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr.

First Name	**M.I.**	**Last Name**	**Sex** ◯ Male	◯ Female
Birth Date	**Age**	**Soc. Sec. #**		
Street	**Apt**	**City**	**State**	**Zip**
Home Tel #	**Cell #**	**Email**		
Referred By (First Name)		**(Last Name)**		

Has a family member ever been a patient of our practice? ◯ Yes ◯ No

Dentist First Name	**Last Name**
Orthodontist First Name	**Last Name**
Medical Doctor First Name	**Last Name**
Nearest Relative Not Living with You	**Tel #**
Employer	**Bus. Tel #**

In case of emergency, please contact:

First Name	**Last Name**	**Relation**	**Tel #**

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

◯ Self (if self, skip this section) ◯ Spouse ◯ Father ◯ Mother ◯ Other _____

First Name		**Last Name**	**Soc. Sec. #**	
Birth Date	**Age**	**Driver Lic #**		
Street	**Apt**	**City**	**State**	**Zip**
Home Tel #	**Cell #**	**Email**		
Employer			**Bus. Tel #**	

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)

First Name		**Last Name**	**Relation**	
Birth Date		**Soc. Sec. #**	**Tel #**	
Street	**Apt**	**City**	**State**	**Zip**
Employer			**Bus. Tel #**	

INSURANCE INFORMATION

Student ◯ Full Time ◯ Part Time ◯ Not _____

School Name **Address**

Marital Status ◯ Married ◯ Divorced ◯ Widow ◯ Single ◯ Legally Separated

City **State** **Zip**

Employed ◯ Full Time ◯ Part Time ◯ Retired ◯ Not

DENTAL INSURANCE

	PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
Employer		
Business Address		
Business Tel #		
Plan		
Insurance Co. Name		
ID #		
Address		
Tel #		
Group Name		
Group #		
Subscriber Name		
Relation		
Birth Date		
Sex	◯ Male ◯ Female	◯ Male ◯ Female
Soc. Sec. #		
Tel #		
Address		

MEDICAL INSURANCE

	PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
Employer		
Business Address		
Business Tel #		
Plan		
Insurance Co. Name		
ID #		
Address		
Tel #		
Group Name		
Group #		
Subscriber Name		
Relation		
Birth Date		
Sex	◯ Male ◯ Female	◯ Male ◯ Female
Soc. Sec. #		
Tel #		
Address		

MEDICAL HISTORY

When was your last medical exam? (mm/dd/yyyy)

Are you presently under a Physician's care?	◯ Yes	◯ No
Are you having pain or discomfort at this time?	◯ Yes	◯ No
Do you feel very nervous about having dental treatment?	◯ Yes	◯ No
Have you ever had a bad experience in a dental office?	◯ Yes	◯ No
Have you been a patient in the hospital during the past two (2) years?	◯ Yes	◯ No
Have you been under the care of a medical doctor during the past two (2) years?	◯ Yes	◯ No
Have you ever had any excessive bleeding requiring special treatment?	◯ Yes	◯ No
When you climb stairs or walk, do you ever have to stop due to chest pain, shortness of breath or being very tired?	◯ Yes	◯ No
Have you been required to restrict your work or activities?	◯ Yes	◯ No
Do your ankles swell during the day?	◯ Yes	◯ No
Do you use more than two (2) pillows to sleep (as ordered by your physician)?	◯ Yes	◯ No
Have you lost or gained more than ten (10) pounds in the last year?	◯ Yes	◯ No
Do you ever wake up from sleep short of breath?	◯ Yes	◯ No
Are you on a special diet or have you ever taken Fen-Phen?	◯ Yes	◯ No
Have your medical doctor ever said you have a cancer or tumour?	◯ Yes	◯ No
Have you ever been treated for Multiple Myeloma, Breast Cancer Osteropenia or Osteroporosis?	◯ Yes	◯ No
What medications were you given?		
Have you ever been on any "Bone Strengthening" medications?	◯ Yes	◯ No
If Yes, please name the medication(s):		
Name of Dentist, Prosthodontist, Endodontist, Orthodontist, Periodontist or Pedodontist:		

Latex Allergy	◯ Yes	◯ No	**Emphysema**	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No	**Frequent Cough or Cold**	◯ Yes	◯ No
Heart Failure, Disease, or Attack	◯ Yes	◯ No	**Tuberculosis (TB)**	◯ Yes	◯ No
Multiple Myeloma	◯ Yes	◯ No	**Asthma or Bronchitis**	◯ Yes	◯ No
Angina Pectoris	◯ Yes	◯ No	**Hay Fever**	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No	**Sinus Trouble**	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	**Allergies or Hives**	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No	**Diabetes**	◯ Yes	◯ No
Congenital Heart Lesions	◯ Yes	◯ No	**Thyroid Disease**	◯ Yes	◯ No
Scarlet Fever	◯ Yes	◯ No	**Xray or Cobalt Treatment**	◯ Yes	◯ No
Artificial Heart Valves	◯ Yes	◯ No	**Chemotherapy (cancer, leuk)**	◯ Yes	◯ No
Heart Pacemaker	◯ Yes	◯ No	**Arthritis**	◯ Yes	◯ No
Artificial Joints or Valves	◯ Yes	◯ No	**Rheumatism**	◯ Yes	◯ No
Metal Pins or Plates	◯ Yes	◯ No	**Cortisone Medicine**	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	**Glaucoma**	◯ Yes	◯ No
Stroke	◯ Yes	◯ No	**Pain or Popping in Jaw Joints**	◯ Yes	◯ No
Kidney Trouble	◯ Yes	◯ No	**Chronic Infection**	◯ Yes	◯ No
Ulcers	◯ Yes	◯ No	**Chronic Headaches**	◯ Yes	◯ No

Hepatitis (non A, non B)	◯ Yes	◯ No	**Liver Disease**	◯ Yes	◯ No
Hepatitis A (infectious)	◯ Yes	◯ No	**Yellow Jaundice**	◯ Yes	◯ No
Hepatitis B (Serum)	◯ Yes	◯ No	**Blood Transfusion**	◯ Yes	◯ No
Drug Addiction	◯ Yes	◯ No	**Hemophilia**	◯ Yes	◯ No
Venereal Disease	◯ Yes	◯ No	**Cold Sores**	◯ Yes	◯ No
Genital Herpes	◯ Yes	◯ No	**Epilepsy or Seizures**	◯ Yes	◯ No
Fainting or Dizzy Spells	◯ Yes	◯ No	**Nervousness**	◯ Yes	◯ No
Psychiatric Treatment	◯ Yes	◯ No	**Sickle Cell Disease**	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	**Tonsillitis**	◯ Yes	◯ No

Do you take any blood thinning medication?	◯ Yes	◯ No	**Name of medication**
Do you drink alcohol?	◯ Yes	◯ No	**If yes, amount consumed per day or per week**
Do you drink smoke?	◯ Yes	◯ No	**If yes, how much?** **If you quit, how long ago?**
Do you use recreational drugs?	◯ Yes	◯ No	**If yes, please specify**

Are you currently taking or have you ever taken any of the following medications: Zoledronate, Zomeda, Pamidronate, Aredia, Alendronate or Fosamax? If yes, please list:

Do you take any medicines regularly (including aspirin and any over-the-counter preparation)? Please name them:

Do you have any allergies (i.e. itching, rash, swelling of hands and feet), drug reactions or any medicines you've been told not to take? Please list:

Have you or anyone in your family had a reaction to general anesthesia? If yes, please describe the type of reaction:

WOMEN ONLY

Have you ever been treated for breast cancer?	◯ Yes	◯ No
Are you now pregnant?	◯ Yes	◯ No
Practicing birth control or taking birth control pills?	◯ Yes	◯ No
Anticipate becoming pregnant in the near future?	◯ Yes	◯ No

WARNING: Birth control pills are less effective while taking antibiotics. Extra precaution is needed until your next menstrual cycle.

SIGNATURES

All of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medicines change, I will inform the Oral Surgeon at the next appointment without fail.

Signature of Patient, Parent or Guardian **Date**

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