**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Married: YES NO

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Phone: Hm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wk: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Receive Text Alerts Yes or No

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL INSURANCE** YesorNo

Policy Holder SS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL INFORMATION**

What is your problem/concern at this time?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under medical treatment now?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please list any **MEDICATIONS** currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **ALLERGIC** to any medications/metals/latex?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized in the last 5 years? If so, why?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates? YES NO

Have you ever taken Phen-Fen or Redux?

YES NO

Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? YES NO

Do you use tobacco? YES NO

Do you use controlled substances? YES NO

Do you have a persistent cough-more than 3 weeks?

YES NO

**WOMEN ONLY:**

Pregnant? Nursing? Oral contraceptives?

YES NO YES NO YES NO

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?**

Epilepsy/Convulsions/Fainting YES NO

Leukemia YES NO

Diabetes YES NO

Kidney Disease YES NO

AIDS or HIV Infection YES NO

Sexually Transmitted Disease YES NO

Thyroid Problem YES NO

Anemia YES NO

Cancer YES NO

Radiation Therapy YES NO

Arthritis YES NO

Joint Replacement YES NO

Premedication YES NO

Hepatitis YES NO

Rheumatic Fever YES NO

Stomach Troubles/Ulcers YES NO

Hay Fever/Allergies YES NO

Tuberculosis YES NO

Glaucoma YES NO

Liver Disease YES NO

High Blood Pressure YES NO

Low Blood Pressure YES NO

Stroke YES NO

Heart Attack YES NO

Heart Disease/Murmur YES NO

Mitral Valve Prolapse YES NO

Pacemaker YES NO

Angina (chest pains) YES NO

Emphysema YES NO

Asthma YES NO

Respiratory Problems YES NO

High Cholesterol YES NO

Osteoporosis YES NO

Is there anything else we should know about your health that we have not covered?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE**:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. If I am here on an emergency basis, I understand that this examination will address only my immediate problem or emergency and should not be confirmed as a complete examination with resulting treatment.

**PATIENT’S or GUARDIAN’S SIGNATURE DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**