PATIENT INFORMATION (Please print)

Name_____ Today's date _____
Last First M.I.

Address_____
Street City State Zip Code

Home phone #_____ Cell phone #_____ e-mail_____

Preferred contact number (please check one): _____ Home Phone _____ Cell Phone _____ Either is fine

Birthdate_____ Driver's License #_____ State_____

Referred by _____ Social Security #_____

If under age 18, parent/legal guardian name_____

Parent/legal guardian address (if different)_____

Gender: M F Marital Status _____ Spouse's Name_____

Emergency contact name:_____ Phone #:_____

MEDICAL HISTORY (please print)

Physician's name_____ Phone number_____

Physician's address_____
City State

Has there been any change in your general health in the last year?_____Are you currently being treated by a physician?_____ If yes, what is the change or condition being treated?_____

_____

Have you had any serious illness, operation or been hospitalized in the past 5 years? _____ If yes, what? _____

_____

Name of medical specialist (if any): _____ Phone number_____

Please list all medications, prescription or over the counter (OTC), that you are taking._____

_____

Do you smoke? _____ Do you use other tobacco (snuff, chew, bidis)?_____

Yes__ No__ Are you taking or scheduled to begin taking any bisphosphonate medications, such as alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's Disease or any other condition?

Yes__ No__ Were you treated or are you currently scheduled to begin treatment with intravenous bisphosphonates (such as Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer?

Please note that it is imperative that we be aware of any bisphosphonate treatment, past, present or future.

Women only: Are you pregnant?_____ Due date: _____ Nursing? _____Are you taking birth control pills?_____ Hormonal replacement therapy? _____

Allergies: Are you allergic or have you had a reaction to:

Yes	No		Yes	No	
___	___	Local anesthetics (novacaine)	___	___	Penicillin or other antibiotics
___	___	Aspirin	___	___	Codeine or other narcotics
___	___	Metals	___	___	Latex (rubber)
___	___	Sedatives or sleeping pills	___	___	Other_____

Have you ever had or suspected you had:

Heart and Circulatory Conditions:

Yes	No		Yes	No	
___	___	High blood pressure	___	___	Infective endocarditis
___	___	Heart disease, heart attack, or angina	___	___	Congestive heart failure
___	___	Damaged heart valves	___	___	Congenital heart disease (CHD)
___	___	Artificial (prosthetic) heart valve	___	___	Unrepaired, cyanotic CHD
___	___	Heart murmur	___	___	CHD repaired (completely) in last 6 months
___	___	Rheumatic fever	___	___	Repaired CHD with residual defects
___	___	Rheumatic heart disease	___	___	Any blood disorder such as anemia or hemophilia
___	___	Mitral valve prolapse	___	___	Bleeding problems associated with previous
___	___	Pacemaker			extractions, surgery or trauma
___	___	Stroke			

Other:

Yes	No		Yes	No	
___	___	Ulcer/colitis	___	___	Back problems
___	___	Esophageal reflux (persistent)	___	___	Arthritis
___	___	Breathing problems or emphysema	___	___	Rheumatoid arthritis
___	___	Bronchitis or asthma	___	___	Osteoporosis
___	___	Tuberculosis	___	___	Artificial hip, knee or other joint (date_____)
___	___	Kidney trouble or renal dialysis	___	___	Jaw/joint pain
___	___	Chemical dependency	___	___	Hearing difficulties/deafness
___	___	Severe headaches / migraines	___	___	Thyroid problems
___	___	Mental health disorders	___	___	Hepatitis, jaundice or liver disease
___	___	AIDS or HIV	___	___	Cancer, radiation, chemotherapy (which drug?_____
___	___	Sexually transmitted disease			_____)
___	___	Herpes	___	___	Epilepsy, seizures or any neurological disorder
___	___	Eating disorder (anorexia/bulemia)	___	___	Diabetes

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?_____

Is there anything else we should know about your health that is not covered in this form? _____ If yes, what?

_____

Please list any dental problem you are having._____

_____

Are you satisfied with the appearance of your smile? _____

_____

I certify that I have read and understand the above and that, to the best of my knowledge, the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and staff will rely on this information for treating me. I will not hold my dentist or office staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. If I ever have any change in my health, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient (or Parent/Legal Guardian if applicable) Date