NAME	First:	Last:	M.I.

Home Address	**City & Zip Code**	**E Mail**	
Home Phone ( )	**Work Phone**	**May We Call Work #**	
Cell Phone	**Occupation /**	**Employer**	
Social Security #	**Date of Birth**	**Full Time Student? School Name**	
Referring Doctor	**General Dentist**		
Family Physician	**Emergency Contact &Phone**		
If Child Who is Guarantor?	**Dental Insurance Name**	**Group #**	**Phone**
Subscriber Name & Employer	**Subscriber SS / ID Number**	**Subscriber Date of Birth**	

Do You Have Secondary Insurance?

PATIENT INFORMATION & MEDICAL HISTORY

	Yes	No	Not Sure
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? Please explain.			
2. Has there been any change in your general health within the past year? If yes, please explain:			
3. Are you under the care of a physician for a current problem? If yes, explain.			
4. Have you been hospitalized within the past 5 years? Please specify**.**			
5. Have you received therapy for alcoholism or drug addiction during the past 5 yrs.?			
6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to antibiotics / medications / anesthetics? Please List.			
7. Is there any condition concerning your health that the doctor should be told?			
8. Do you wish to speak to the doctor privately about anything?			
9. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
10. Have you ever required a blood transfusion?			
11. Have you ever had radiation?			
12. Have you ever tested positively for HIV infection or AIDS?			
13. Are you required to take antibiotics prior to dental treatment?			
14. Have you ever taken a BISPHOSPHONATE Medication? (Includes Actonel, Boniva, Fosamax, Zometa)			
15. Are you taking any medication or drugs? Please list them below.			

Do you have or have you had any of the following? Check those that apply or check none of the above.

☐	High blood pressure	☐	Sinus trouble
☐	Heart murmur or prolapsed valve	☐	Thyroid problems
☐	Joint prosthesis (hip, knee, etc.)	☐	Diabetes
☐	Rheumatic fever or rheumatic heart disease	☐	Stomach ulcers, colitis
☐	Congenital heart disease	☐	Hepatitis, jaundice, liver disease
☐	Cardiovascular disease:heart attack, stroke, bypass	☐	Psychiatric treatment
☐	Prosthetic heart valve	☐	Fainting spells or seizures
☐	Blood disorder (e.g. anemia)	☐	Epilepsy
☐	Venereal disease	☐	Cancer
☐	Asthma	☐	Temporomandibular joint problems (TMJ)
☐	Allergy to latex	☐	Low blood sugar
☐	Low blood pressure	☐	Dialysis
☐	Chest pain, angina	☐	Irregular heart beat
☐	Swollen ankles, arthritis or joint disease	☐	Current Contagious diseases
☐	Cardiac pacemaker	☐	Bronchitis, chronic cough
☐	Heart surgery	☐	Hay fever or sinus problems
☐	Delay in healing	☐	Problems with the immune system
☐	Tuberculosis	☐	Difficult breathing or other lung trouble
☐	Emphysema	☐	Chronic fatigue or night sweats
☐	Chemotherapy or Radiation	☐	Osteoporosis
☐	On a diet	☐	Wear contact lenses
☐	History of alcohol or drug abuse	☐	Bruise easily
☐	Eye disease or glaucoma	☐	Gallbladder trouble
☐	Infectious mononucleosis	☐	**None of the above**

	Yes	**No**	**Not Sure**
16. Are you taking any herbal medicine (i.e., St. John's Wort)?			
17. Have you ever taken the "fen-phen" diet?			
18. Do you have any disease, condition or problem not listed above? Specify.			

Possibility of pregnancy: **YES / NO**	Nursing: YES / NO
Estimated delivery date:	**Taking birth control pills:** **YES / NO**

Women only: NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

Is visit related to an accident YES / NO	Work related: YES / NO
Date of injury:	
Insurance company handling the claim:	
Claim Number:	