



Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Cell # ( ) \_\_\_\_\_ Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_

Are you currently under a physician's care?  Yes  No If yes, please explain \_\_\_\_\_

Have you ever had a serious illness or surgery?  Yes  No If yes, please explain \_\_\_\_\_

Have you ever taken Phen-Fen or Redux?  Yes  No

Have you ever taken meds for Osteoporosis?  Yes  No

Do you use tobacco?  Yes  No

Please list any medications, pills or drugs you are taking: \_\_\_\_\_

**WOMEN ONLY:** Are you taking birth control?  Yes  No Are You Pregnant?  Yes  No Nursing?  Yes  No

**Do You Have Allergies To Any Of The Following?**

- |   |  |  |   |
|---|--|--|---|
| YES NO  | YES NO   | YES NO   | YES NO  |
| <input type="checkbox"/> <input type="checkbox"/> Aspirin           | <input type="checkbox"/> <input type="checkbox"/> Erythromycin | <input type="checkbox"/> <input type="checkbox"/> Metals       | <input type="checkbox"/> <input type="checkbox"/> Other |
| <input type="checkbox"/> <input type="checkbox"/> Codeine           | <input type="checkbox"/> <input type="checkbox"/> Jewelry      | <input type="checkbox"/> <input type="checkbox"/> Penicillin   | _____   |
| <input type="checkbox"/> <input type="checkbox"/> Dental Anesthetic | <input type="checkbox"/> <input type="checkbox"/> Latex        | <input type="checkbox"/> <input type="checkbox"/> Tetracycline | _____   |

**Check Any Of The Following That Apply To Patient Health History:**

- |   |   |  |
|---|---|--|
| Y N   | Y N   | Y N  |
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding         | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells       | <input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints   |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse             | <input type="checkbox"/> <input type="checkbox"/> Fever Blisters        | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's               | <input type="checkbox"/> <input type="checkbox"/> Freq. Headaches       | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy    |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                    | <input type="checkbox"/> <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris           | <input type="checkbox"/> <input type="checkbox"/> HIV+/AIDS             | <input type="checkbox"/> <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> <input type="checkbox"/> Shingles             |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> <input type="checkbox"/> Heart Surgery         | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell          |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                    | <input type="checkbox"/> <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> <input type="checkbox"/> Stroke / TIA         |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/Chemo              | <input type="checkbox"/> <input type="checkbox"/> Hepatitis B/C         | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> <input type="checkbox"/> Colitis                   | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement     | <input type="checkbox"/> <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing      | <input type="checkbox"/> <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice      |
| <input type="checkbox"/> <input type="checkbox"/> Drug Abuse                | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> <input type="checkbox"/> Pacemaker             |  |

Do you have any disease, condition or problem not listed above?  Yes  No If yes, please explain \_\_\_\_\_

I understand the above information is necessary to provide the safest and most efficient dental care for me. I certify I have read and answered the above questions to the best of my knowledge. I will not hold my dentist or any member of the dental team/staff responsible for any errors or omissions that I have made in the completion of this form. I hereby agree to notify the dentist if any changes occur to my reported health status.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_