

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Ext. _____

Birthdate _____ Sex M F Marital Status _____

Employer _____ Occupation _____ No. of Years Employed _____

If patient is a minor, give parent's or guardian's name _____

List other family members _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle

Mailing Address _____
Street City State Zip

Residence if different _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Ext. _____

Previous Address (if less than 3yrs.) _____

Birthdate _____ Sex M F Marital Status _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Birthdate _____
Last First Middle

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Work Phone _____ Ext. _____

Emergency Information

Name of emergency contact not living with you _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Ext. _____

Health History

Patient Name _____

Physicians Name _____

Address _____ Phone# _____

Are you receiving any medical treatment or have you been hospitalized within the last year? Yes No

If so, explain _____

Are you taking any prescription or non prescription medications? Yes No

If so, list them _____

Are you allergic or have you reacted adversely to any of the following medications: *(Please check if yes)*

- | | | | |
|---------------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Darvon | <input type="checkbox"/> Metals | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex Rubber | <input type="checkbox"/> Percodan |
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Vicodeine | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Local Anesthetic (Novocaine) |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Tylox | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Other _____ |

Are you aware of being allergic to any other medication or substance? Yes No

If yes, please list: _____

Have you ever had any of the following: *(Please check if yes)*

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV-AIDS |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Cardiac Pace Maker | <input type="checkbox"/> Tumor or Growth | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dental Implants |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach Troubles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Sexually Transmitted Disease |

Have you or are you now taken any Bisphosphonate Medications? Yes No

Do you wear contact lenses? Yes No

Has anyone in your family had diabetes? Yes No

Do you smoke or use tobacco products? Yes No

Have you ever been pre-medicated for dental treatment? Yes No

If so, type of medication _____

- FOR WOMAN ONLY:
- Are you pregnant or think you may be?
 - Are you nursing?
 - Are you taking oral contraceptives?

Patient Signature (Parent or Guardian): _____ Date: _____