PATIENT NAME: **DATE OF BIRTH: - - M / F**

HOME PHONE: **CELL/ WORK:** **FAMILY DENTIST:**

HOME ADDRESS: **CITY:** **ZIP CODE:**

PATIENT SOCIAL SECURITY #: - - **EMPLOYED BY:**

EMERGENCY CONTACT: **PHONE NUMBER:**

PRIMARY DENTAL INSURANCE CARRIER: **SUBSCRIBER NAME:** **SUBSCRIBER EMPLOYED BY:**

SUBSCRIBER / PARENT SOCIAL SECURITY NUMBER: - - **SUBSCRIBER DATE OF BIRTH: - -** **IS THERE A SECONDARY DENTAL INSURANCE? Y N**

HEALTH QUESTIONS

YES NO

☐ ☐ **Are You Currently Under a Physician's Care for a Specific Medical Condition?**

☐ ☐ **Are You Currently Taking Any Medications? Please List (Including Aspirin, Birth Control, or Herbal Supplements):**

_____

_____

☐ ☐ **Are You Subject To Prolonged Bleeding?**

☐ ☐ **Are You Nursing or Pregnant? How Many Months? ___**

☐ ☐ **Hip Or Other Joint Replacement? When? _____**

☐ ☐ **Do You have TMD (Jaw Problems)?**

☐ ☐ **Do You Normally Take Antibiotics Before Dental Appointments?**

PLEASE CIRCLE ANY ILLNESS YOU HAVE HAD OR HAVE AT PRESENT:

prosthetic heart valve	anemia	IV drug use	bisphosphonate therapy
rheumatic fever	hemophilia	AIDS / HIV positive	(Zometa, Aredia, Fosamax, etc)
stroke	diabetes	venereal disease	for osteoporosis
heart murmur	heart trouble	blood disorders	
chemical dependence	epilepsy	hepatitis	
high blood pressure	psychiatric treatment	fainting spells	
mitral valve prolapse	asthma	radiation therapy	
heart attack	respiratory disease	hay fever / allergies	
pacemaker	tuberculosis	intestinal problems	
bacteremia	transfusion	kidney trouble	
angina	thyroid problems	liver problems	

CIRCLE ITEMS TO WHICH YOU HAVE REACTIONS OR ALLERGIES:

penicillin	aspirin	tetracycline	local anesthetic
clindamycin	ibuprofen	codeine	latex

LIST OTHERS: _____

IS THERE ANY OTHER INFORMATION REGARDING YOUR HEALTH OR PAST EXPERIENCES WITH DENTAL TREATMENT / ROOT CANALS THAT WE SHOULD KNOW? _____

_____

I hereby certify that the above information is correct to the best of my knowledge:

_____ _____

TODAY'S DATE **SIGNATURE OF PATIENT, PARENT OR GUARDIAN**