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

HOME/ FAMILY

CELL PHONE: **WORK:** **DENTIST:**

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

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

EMERGENCY CONTACT: **PHONE NUMBER:**

PRIMARY DENTAL INSURANCE CARRIER: **SUBSCRIBER NAME:** **IS THERE A SECONDARY DENTAL INSURANCE? Y N**

SUBSCRIBER SOCIAL SECURITY # - - **SUBSCRIBER DATE OF BIRTH: - -** **SUBSCRIBER EMPLOYEED BY:**

HEALTH QUESTIONS

YES	NO	
☐	☐	**Are You Currently Under a Physician's Care for a Specific Medical Condition? (Please List)**
☐	☐	**Are You Currently Taking Any Medications? Please List (Including Aspirin, Birth Control, or Herbal):**

YES	NO	
☐	☐	**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?**
☐	☐	**Have Your Ever Taken Bisphosphonate (Osteoporosis) Drugs (Fosamax, Boniva, Actonel, etc)?**
☐	☐	**Do You Have Any Non-Healing Sores In or Around Your Mouth?**

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

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

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 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**