



GENERAL INFORMATION

Answers to all questions are for office use only and are strictly confidential.

Name: Birth Date: Age: Male Female
Address: City: State: Zip:
Home Phone: Business Phone: Cell Phone:
E-mail address: Soc. Sec. #: Marital Status:
Occupation: Employer:
Spouse (or Parents/Guardian) - Name: Employer:
Emergency Contact: Phone Number:
Do you have dental insurance? Yes No Dental Insurance Co.:
Policy Holder - Name: SS # or ID#: Birth Date:
General Dentist: Referred By:
Physician's Name: Address:

MEDICAL HISTORY

Are you being treated by a physician or a psychiatrist now? Yes No
Date of last physical exam: Height: Weight:

Please mark an 'X' in the box if you have/had any of the following:
Rheumatic Fever, Arthritis, Drug Addiction, Angina/Chest Pains, Osteoporosis/Osteopenia, Alcoholism, Heart Murmur, Bleeding Problems (anemia), Venereal Disease, Heart Valve Replacement, Hemophilia, Herpes, High Blood Pressure, Joint Replacement, HIV, AIDS, Low Blood Pressure, Liver Disorder (jaundice, hepatitis), Glaucoma, Heart Attack, Stomach Problems (ulcers), Depression, Mitral Valve Prolapse, Diabetes, Sinus Problems, Pace Maker, Skin Disease (hives), Blood Transfusion, Kidney Disorder, Lupus, Epilepsy, Seizures, Dialysis, Leukemia, Cancer (type), Lung Problems (tuberculosis, COPD), Thyroid Disease, Other, Asthma, Stroke

Have you ever been seriously ill or hospitalized? Yes No If yes, explain:
Are you taking any medication or herbal supplements? Yes No
If yes, please list:

Are you allergic to or have any unusual reaction to any medications? Yes No
If yes, please list:

Have you ever taken or are you currently taking any bisphosphonate medications (i.e. Boniva, Fosamax)? Yes No
If yes, are you aware of the dental risks associated with these medications? Yes No
Do you require antibiotic premedication prior to any dental appointments? Yes No
Do you currently smoke or chew tobacco? Yes No If yes, how much: how long:
Women, are you pregnant at the present time? Yes No

I certify that the above information is accurate. I will notify the doctor of any change in my health or medication.

Date:

Patient/Guardian Signature:

OFFICE USE ONLY