

Name: _____ Today's Date: _____ Social Security # _____

Date of Birth: _____ E-mail Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Home# _____ Wk# _____ Cell# _____

In case of an emergency whom should we contact? Name: _____

Whom may we thank for referring you?

Health and Dental History

Have you been under the care of a medical doctor during the past two years? Yes No

If so, for what? _____

Are you taking any medication now, including regular dosages of aspirin? Yes No

If so, please list name and dosage _____

Are you aware of having an allergic reaction to any medication or substance? Yes No

If so please list _____

Are you currently taking are have taken in the past the following medications? Circle any that apply.

Fosamax Actonel Boniva Zometa Aredia

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes	No	AIDS / HIV	Yes	No	Sensitive Teeth	Yes	No
Congenital Heart Disease	Yes	No	Sickle Cell Disease	Yes	No	Neck Pain	Yes	No
Heart Murmur	Yes	No	Neurological Disorders	Yes	No	Bell's Palsev	Yes	No
High Blood Pressure	Yes	No	Psychiatric / Psychological	Yes	No	Difficulty Swallowing	Yes	No
Mitral Valve Prolapse	Yes	No	Headaches	Yes	No	Difficulty Chewing	Yes	No
Artificial Heart Valve	Yes	No	Jaw Pain	Yes	No	Trigeminal Neuralgia	Yes	No
Pacemaker	Yes	No	Jaw Popping	Yes	No	Tingling in arms / fingers	Yes	No
Stroke	Yes	No	Limited Opening	Yes	No	Insomnia / frequent waking	Yes	No
Asthma	Yes	No	Loose Teeth	Yes	No	Have you had braces?	Yes	No
Liver Disease/iaundice	Yes	No	Posture Problems	Yes	No	Do you see a chiropractor?	Yes	No
Latex Sensitivity	Yes	No	Clenching	Yes	No	Does floss shred when you use it?	Yes	No
Artificial joints	Yes	No	Grinding	Yes	No	Does food pack or catch between your teeth?	Yes	No
Kidney trouble	Yes	No	Facial Pain	Yes	No	Do you smoke or chew tobacco?	Yes	No
Radiation / Chemotherapy	Yes	No	Snoring	Yes	No	Do your gums bleed?	Yes	No
Epilepsy / seizures	Yes	No	Told you snore?	Yes	No	Do you get fever blisters?	Yes	No
Diabetes	Yes	No	Sleep Apnea	Yes	No	If yes, do you take prescription medicine	Yes	No
Hepatitis	Yes	No	Do you have a CPAP?	Yes	No	For fever blisters?		

Do you have or have had any disease, condition or problem not listed? _____

Women: Are you pregnant? _____ Nursing? _____ Taking birth control pills? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication. I understand that I am financially responsible for all charges.

Signature: _____ Date: _____