PATIENT INFORMATION

Name:_____ Date:_____
Last First Middle
□ Male □ Female □ Married □ Single □ Child □ Other_____
Social Security Number:_____ Date of Birth:_____
Phone(Home):_____(Work)_____(Cell)_____
Address:_____

HEALTH INFORMATION

Do you have or have you had any of the following?

□ AIDS/HIV	□ Epilepsy/ Seizures	□ Mental/Nervous Disorders
□ Anemia	□ Emphysema	□ Mitral Valve Prolapse
□ Angina	□ Excessive Bleeding	□ Osteoporosis
□ Arthritis	□ Fainting Tendency/ Dizziness	□ Prolonged Bleeding
□ Artificial Joints/Implants	□ Glaucoma	□ Radiation Therapy
□ Artificial Heart Valve	□ Head/Face Injury	□ Respiratory Problems
□ Asthma/Hay Fever	□ Heart Attack	□ Rheumatic Fever
□ Blood Disease	□ Heart Disease	□ Sexually Transmitted Disease
□ Blood Transfusion	□ Heart Murmur	□ Shortness of Breath
□ Cancer	□ Hepatitis/ Jaundice	□ Sinus Problems
□ Cardiac Pacemaker	□ High/Low Blood Pressure	□ Stomach Problems/Ulcers
□ Chemotherapy	□ Kidney Disease	□ Stroke
□ Chest Pains	□ Leukemia	□ Thyroid Disease
□ Congenital Heart Disease	□ Liver Disease	□ Tuberculosis
□ Diabetes	□ Lung Disease	□ Tumors/ Growths

Physician's Name:_____ Phone Number:_____

	YES	NO
1. Are you under medical treatment now?	□	□
If yes please explain:_____		
2. Have you seen your medical doctor in the past two years?	□	□
If yes please explain:_____		
3. Have you been hospitalized in the past five years?	□	□
If yes please explain:_____		
4. Do you take any medications?	□	□
If yes please list ALL medications in the box to the right.		
5. Do you use tobacco products?	□	□
6. Are you taking or have you ever taken any kind of bisphosphonate medication(Fosamax, Actonel, Boniva, etc)?	□	□

MEDICATIONS

7. Are you allergic to: □ Penicillin □ Latex □ Local anesthetics □ Codeine □ Aspirin □ Nothing
OTHER_____
8. <u>WOMEN ONLY</u>: Are you: □ Pregnant/trying to get pregnant □ Nursing □ Taking birth control pills

To the best of my knowledge, the questions pertaining to my health history have been answered accurately. I will inform the dentist or the office staff of any changes in my health and medications.

_____
Signature of Patient, Parent, or Guardian Date