# PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

DATE ____________________

NAME ____________________________________________ BIRTH DATE _________ AGE _____ HOME PHONE ____________________
FIRST MI LAST

ADDRESS ____________________________________________ CITY ________________________ STATE _______ ZIP ________

EMAIL ADDRESS ____________________________________________ CELL PHONE ____________________

NAME OF REFERRING DENTIST ____________________________________________

CHECK APPROPRIATE BOX ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S
EMPLOYER ____________________________________________ WORK PHONE ____________________

BUSINESS ADDRESS ____________________________________________ CITY ________________________ STATE _______ ZIP ________

SPOUSE OR PARENT/GUARDIAN'S
NAME ____________________________________________ EMPLOYER ____________________ WORK PHONE ____________________

PERSON TO CONTACT IN CASE OF EMERGENCY ____________________________________________ PHONE ____________________

# PATIENT MEDICAL HISTORY

PHYSICIAN ______________________________ OFFICE PHONE ____________________ DATE OF LAST EXAM ____________________

*Height* _______ *Weight* ________

| | YES | NO |
|---|---|---|
| 1. ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN OR BEEN HOSPITALIZED IN THE LAST 5 YEARS? | ☐ | ☐ |
| 2. HAVE YOU EVER HAD PROLONGED BLEEDING FROM AN INJURY OR TOOTH EXTRACTION? | ☐ | ☐ |
| 3. ARE YOU TAKING ANY DRUGS, MEDICATIONS OR VITAMINS AT THIS TIME? (LIST) ______________________________ | ☐ | ☐ |
| 4. ARE YOU ALLERGIC TO ANY DRUGS, MEDICATIONS, LATEX OR METALS? (LIST) ______________________________ | ☐ | ☐ |
| 5. ARE YOU OR HAVE YOU EVER TAKEN MEDICATION TO PREVENT OSTEOPOROSIS? | ☐ | ☐ |
| 6. HAVE YOU RECEIVED THERAPY FOR ALCOHOLISM OR DRUG ADDICTION IN THE PAST 5 YEARS? | ☐ | ☐ |

7. WOMEN ONLY:

| | YES | NO |
|---|---|---|
| A) ARE YOU PREGNANT/POSSIBLY PREGNANT? | ☐ | ☐ |
| B) ARE YOU NURSING? | ☐ | ☐ |
| C) ARE YOU TAKING BIRTH CONTROL PILLS? | ☐ | ☐ |

8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | HEART DISEASE/TROUBLE | ☐ | ☐ | KIDNEY DISEASE | ☐ | ☐ | STOMACH TROUBLE/ULCERS |
| ☐ | ☐ | ARTIFICIAL HEART VALVE | ☐ | ☐ | TUBERCULOSIS | ☐ | ☐ | TMJ DISORDER |
| ☐ | ☐ | CARDIAC PACEMAKER | ☐ | ☐ | HERPES | ☐ | ☐ | THYROID PROBLEM |
| ☐ | ☐ | RHEUMATIC FEVER | ☐ | ☐ | AIDS OR HIV INFECTION | ☐ | ☐ | RADIATION THERAPY |
| ☐ | ☐ | HIGH BLOOD PRESSURE | ☐ | ☐ | JOINT REPLACEMENT OR IMPLANT | ☐ | ☐ | SINUS PROBLEMS |
| ☐ | ☐ | STROKE | ☐ | ☐ | ASTHMA/EMPHYSEMA | ☐ | ☐ | RESPIRATORY PROBLEMS |
| ☐ | ☐ | DIABETES | ☐ | ☐ | GLAUCOMA | ☐ | ☐ | ARTHRITIS |

9. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE? ______________________________

**SIGNATURE** ______________________________

**OFFICE USE** ______________________________

______________________________ ____________________ ________
SIGNATURE OF DOCTOR DATE