Last Name:_____ First Name: _____Preferred Name:_____

Middle: _____ Title: Dr. Mr. Mrs. Ms. Miss Home Phone: _____

Address: _____ Work:_____

City _____ST_____ ZIP _____ Cell: _____

Male / Female Social Security: _____ DOB:_____

Referring Dentist or Patient:_____ Dentist Phone: _____

General Physician: _____ Phys. Phone: _____

Patient E-Mail Address: _____

Emergency Contact: _____ Phone _____

Allergies:
( ) Aspirin
( ) Codeine
( ) Dental Anesthetics
( ) Erythromycin
( ) Jewelry
( ) Latex
( ) Metals
( ) Penicillin
( ) Tetracycline
( ) Sulfa

Check any of the following that you are taking or have taken:

( ) Cortisone Drugs
( ) Tranquilizers
( ) Steroids
( ) Sedatives
( ) Anticoagulants
( ) Bisphosphinates
( ) Blood Thinners

List medications and dosage you are currently taking:

_____
_____
_____
_____
_____
_____
_____

( ) Abnormal Bleeding
( ) Acid Reflux
( ) Allergies
( ) Anemia
( ) Angina Pectoris
( ) Arthritis
( ) Artificial Joint Replacement
( ) Asthma
( ) Barbiturates
( ) Bleeding Disorders
( ) Blood Transfusion
( ) Cancer / Tumor Chemotherapy
( ) Chemical Dependency
( ) Depression / Nervousness
( ) Diabetes Type 1 or 2
( ) Difficulty Breathing

( ) Difficulty Swallowing
( ) Emphysema
( ) Epilepsy
( ) Fever Blisters
( ) Glaucoma
( ) HIV Positive or Aids
( ) Hay Fever
( ) Heart Disease
( ) Hepatitis or Jaundice
( ) High Blood Pressure ( ) Low BP
( ) Iodine Allergy
( ) Kidney / Bladder Trouble
( ) Neuralgia
( ) Pacemaker
( ) Psychiatric Problems

( ) Radiation Treatment
( ) Seizures
( ) Shingles
( ) Shortness of Breath
( ) Sinus Trouble
( ) Sleep Apnea
( ) Stroke
( ) Thyroid Problems
( ) Tuberculosis
( ) Ulcers
Do you have any other conditions/problems not covered above? Yes No If yes, describe:
_____
_____

Do you Smoke? Yes No Premedication requirement? (Artificial joint replacement) Yes No

Current Dentist: _____ Previous Dentist: _____

Last Dental Visit _____ Last Dental X-Rays: _____

What is the presenting problem?_____

What is the history of the problem?_____

What is your desired outcome?_____

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____