



CONFIDENTIAL MEDICAL INFORMATION

Patient's Name: _____ DOB: _____ Home Phone: () _____

Street Address: _____ Work Phone: () _____

City: _____ State: _____ ZIP: _____ E-Mail _____

Social Security Number: _____ Sex: Male Female Patient Employer: _____

Emergency Contact: _____ Phone: _____ Relationship _____

Spouse's Name: _____ Referred by: _____

Primary Physician: _____ Phone: _____ City & State _____

Date of Last Physical Examination: _____ Date of Last Blood Test/Workup: _____

Other Physicians or Specialists:

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Name: _____ Specialty: _____ Phone: _____ City & State: _____

If you are completing this form for another person:

Your Name: _____ Relationship: _____ Phone: () _____

Within the last three years have you been hospitalized or had surgery? YES NO

If yes, please give reasons and dates: _____

Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments?

YES NO If yes, please explain: _____

1. Are you taking, or have you ever taken medications for osteoporosis? YES NO

2. Are you taking any drugs, medications, or treatments at this time? YES NO

(If you brought a complete written list with you; please give that to the receptionist.)

Prescribed: _____

Over-The-Counter Meds (such as aspirin, ibuprofen, allergy meds, sleeping aids, Vitamins, Natural or Herbal Preparations, and Dietary Supplements):

Are you having, or have you ever had radiation or chemotherapy treatments? YES NO

If yes, for how long? _____ Name of facility performing the therapy: _____

3. Are you allergic to, or have you ever experienced any unusual reaction to:

- | | | | |
|-----------------------------------|---|--|-------------------------------|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Metals or Jewelry | <input type="checkbox"/> Dental Anesthesia (Local/Novocaine) | <input type="checkbox"/> None |
| <input type="checkbox"/> Fluoride | <input type="checkbox"/> Nitrous Oxide (Laughing Gas) | <input type="checkbox"/> General Anesthesia | |

4. Are you allergic to, or have you ever had any reaction to the following drugs? YES NO

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Penicillin (or Related Drugs) | <input type="checkbox"/> Tranquilizers (Valium) | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Prescription Pain Medication |
| <input type="checkbox"/> Aspirin/Ibuprofen (Advil, Motrin, Nuprin) | <input type="checkbox"/> Keflex (Cephalexin) | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> NSAID (Celebrex, Anaprox) | <input type="checkbox"/> Clindamycin (Cleocin) | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> None |

5. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills or treatments? YES NO

If yes, please list: _____

Continue on Back...

Do you have, or have you ever had any of the following? (Please check YES or NO for each question.)

	YES	NO		YES	NO
6. a. Congenital Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	7. a. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
b. Angina or Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	b. Hay Fever, Skin Allergies, Food Allergies, or Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>
c. Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	c. Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
d. Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	d. Tuberculosis, Emphysema or Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>
e. Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	e. Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	f. A Sore or Wound that Bleeds Easily or Does not Heal	<input type="checkbox"/>	<input type="checkbox"/>
if Yes, Date: _____			g. A Thyroid Problem or Disease	<input type="checkbox"/>	<input type="checkbox"/>
g. Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	h. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, Date: _____			i. Glaucoma or any Eye Diseases	<input type="checkbox"/>	<input type="checkbox"/>
h. Rhumatic Heart Disease/Rhumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	j. Epilepsy or Other Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
i. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	k. Any Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
j. Heart Valve(s) Damage/Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	l. Ulcers, Acid Reflux, or Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
k. Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	m. A Compromised Immune System (Lupus, HIV, AIDS, Radiation Immune Problems, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
l. Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	n. An Active Sexually Transmitted Disease (STD)	<input type="checkbox"/>	<input type="checkbox"/>
m. Stroke or CVA	<input type="checkbox"/>	<input type="checkbox"/>	o. Any Mental Health Issues	<input type="checkbox"/>	<input type="checkbox"/>
n. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	p. Been Treated for Any Psychiatric Condition	<input type="checkbox"/>	<input type="checkbox"/>
o. Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	q. Do you smoke or chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
p. Anemia	<input type="checkbox"/>	<input type="checkbox"/>			
q. Hemophilia or Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
r. Excessive Bleeding from any Cut or Incident	<input type="checkbox"/>	<input type="checkbox"/>			
s. Diabetes or Blood Sugar Problems	<input type="checkbox"/>	<input type="checkbox"/>			
t. Any Artificial Joint, Joint Surgery, or Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, what joint or area? _____					
Date of surgery: _____					
u. Hepatitis, Jaundice, or Other Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>			
If Hepatitis, type? _____					
v. Any Form of Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Type of Cancer _____					
w. An Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>			

8. Women Only:

	YES	NO
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what is your due date? _____		
Do you think that you might be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you using birth control medication?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking hormone replacement therapy?	<input type="checkbox"/>	<input type="checkbox"/>

9. Do you have any other conditions, diseases, medical problems, or is there ANY other information that you would like us to know about or that we should be made aware of? YES NO If yes, please explain:



Patient Signature:
(Parent or Guardian if under 18)

Date:

For Office Use Only

Provider: