### PATIENT INFORMATION

|  |  |
| --- | --- |
| Patient Name: | Date of Birth: |
| Ethnicity: | Sex: |
| Social Security #: | Home Phone: | Cell: |
| Address: | Patient Height: |
| Patient Weight: |
| How did you find out about us? |
| Reason for seeking dental treatment: |
| Have you had any problems with dental treatment in the past? |

### CHECK BOX IF ANY OF THE FOLLOWING APPLIES:

|  |  |
| --- | --- |
| * Cardiovascular Disease - Heart Attack, Angina, Atherosclerosis, Stroke (please circle)
 | * History of infective endocarditis, artificial heart valves, heart defects (please circle)
 |
| * High blood pressure
 | * Diabetes (Type I or II) HbA1C: %
 |
| * Hepatitis or liver disease (If yes, list type)
 | * Kidney disorders
 |
| * GERD or heartburn
 | * Stomach ulcers
 |
| * HIV or AIDS (If yes, please list meds)
 | * Autoimmune disorders
 |
| * Arthritis
 | * Osteoporosis
 |
| * Respiratory problems - Emphysema, Bronchitis,
* COPD, Tuberculosis (please circle)
 | * Asthma
 |
| * Seizures (If yes, list type and frequency)
 | * Low blood pressure or syncope (please circle)
 |
| * Intellectual or developmental disability
 | * Mental health disorders
 |
| * Anemia or sickle cell anemia (please circle)
 | * Bleeding disorders (If yes, list type)
 |
| * Thyroid disorders
 | * Sleep apnea
 |
| * Eating disorders
 | * Cyclic vomiting syndrome
 |
| * Cancer (If yes, list type and treatment)
 | * Pregnant or nursing
 |
| * Alcohol abuse
 | * Drug abuse
 |
| * Tobacco use: type: amount/day: years of use:
 |
|  |
| Do you have any disease, disorder, or complicated not mentioned above? If yes, please explain: |
| Have there been any changes in your general health in the last year? |
| Have you taken or are you currently taking any bisphosphonates (Fosamax, Zometa, Actonel, Boniva, Didronel) for Osteoporosis, Multiple Myeloma, or Cancer Therapy? Please list the name and when you went on the medication. |
| What medications (prescribed or non-prescribed) are you currently taking? |
|  |
| Have you ever required antibiotics prior to dental appointments? |

### are you allergic to any of the following medications?

|  |  |
| --- | --- |
| * Local or topical anesthetic
 | * Penicillin/other antibiotics
 |
| * Aspirin
 | * Codeine
 |
| * Opiates
 | * Benzodiazepines
 |
| * Other:
 | * No Known drug allergies
 |

### please circle yes or no to the following questions and provide any relevant information:

|  |  |
| --- | --- |
| Are you interested in dental treatment under sedation? | YesNo |
| Have you had any problems with sedation or general anesthesia in the past? | YesNo |
| Have you ever been hospitalized or undergone any surgeries? Please describe. | YesNo |
| **Additional comments:** |

### contact information

|  |  |  |
| --- | --- | --- |
| Conservator (If applicable): | E-mail: | Phone: |
| Parent/Guardian (for patients under 18): | E-mail: | Phone: |
| Primary Care Physician: | Fax:  | Phone: |
| Pharmacy Name: | Fax:  | Phone:  |
| DENTAL insurance INFORMATION (if applicable) |
| Person responsible for Account (If different from patient): |
| Date of Birth:  | Social Security # |
|  |
| I understand that withholding any information about the patient’s health could seriously jeopardize his/her safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | Signature |  | Date |  |

 |

 **\*\*Please provide front/back copies of any dental insurance card (if applicable).**