PATIENT'S NAME Mr. / Mrs. / Miss / (minor) ______________________

Today's Date ______________
Marital Status S M D W
Date of Birth ______________

Responsible Party__________Self__________Other(Name)____________________Name of Spouse______________

Home address ______________________________ Home Telephone ______________

City________________ State________ Zip________ E-Mail________________ Cell.#______________

Employed by ______________________ SS # ______________ Work Telephone______________

Do you have dental insurance through your employer? ______________ With which insurance company? ______________

Do you have dental insurance through your spouse's employer?______________ With which insurance company? ______________

Nearest relative not living with you ______________ Phone # ______________

How did you hear about our office? ______________________

MEDICAL HISTORY

Because we don't want to prescribe any medication or perform any treatment that would endanger you or interfere with medications you are currently taking, we kindly ask you to fill out this medical history as accurately as possible. ***Thank You!***

1. When did you last visit your medical doctor? ______________________
   Why?______________________
2. Please list any drugs or medications you are currently taking: ______________________
3. Are you taking, or have you taken bisphosphonates for Osteoporosis Such as Fosamax, Aredia, Zometa? ☐ Yes ☐ No
4. Please note any present illness or conditions of which we should be aware: ______________________
5. a) Please list any drugs to which you are allergic or sensitive: ______________________
   b) Please list any metals or plastics or other materials to which you have an allergy or contact sensitivity: ______________
6. Have you been hospitalized in the last 5 years? ______________________
7. Females: are you or could you be pregnant?__________ If so, name and phone number of obstetrician: ______________
8. Do you have, or have you ever had any of the following diseases? (Please circle yes or no):

YES NO Rheumatic Fever
YES NO Heart murmur or Mitral valve prolapse
YES NO Heart trouble
YES NO High or low blood pressure
YES NO Stroke
YES NO Diabetes
YES NO Liver Disease (Hepatitis, jaundice)
YES NO Ulcers or other stomach or intestinal troubles
YES NO T.B. or other lung disease
YES NO Joint replacements (Hip, Knee)
YES NO Nervous conditions
YES NO Kidney disease
YES NO Epilepsy
YES NO Tumors or cancer
YES NO Hay fever or asthma
YES NO Radiation or chemotherapy for cancer
YES NO Venerial disease or AIDS
YES NO Thyroid problems
YES NO Ear, eye, nose or throat problems
YES NO Allergic reactions to medications
YES NO Canker sores or fever blisters
YES NO Unusual prolonged bleeding from cuts or previous tooth extractions
YES NO Other (explain)______________________

DENTAL HISTORY

How long since your last visit to a dentist?__________ Name and Phone # ______________________

Type of treatment rendered? ______________________

Has fear of dentistry kept you from receiving dental treatment in the past? ______________________

How is your overall dental condition? ______________________

How important is it to you to save your teeth for a lifetime? ______________________

Are you satisfied with the appearance of your teeth? ______________________

Reason for present dental visit? ______________________

I UNDERSTAND THAT INSURANCE IS FILED AS A COURTESY AND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED.

Signature ______________________
If minor child, parent's signature