



Name: _____ Today's Date: ___/___/___ Birthdate: ___/___/___

Home Phone Number: (____) _____ Cell Phone Number: (____) _____

Email Address: _____

I'd like to receive email confirmations. Yes No I'd like to receive text confirmations. Yes No

Medical History

Do you have a personal physician? Yes No

Date of your last physical exam. _____

Physician's Name: _____

Address: _____
City State Zip

Phone #: (____) _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken bisphosphonate medication for conditions such as osteoporosis? Yes No

Are you taking any prescription, over-the-counter drugs or suppliments? Yes No

If yes, please list each one: _____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Barbiturates

Y N Jewelry Y N Sulfa Drugs Y N Codeine

Y N Latex Y N Dental Anesthetics Y N Seasonal Hayfever

Y N Penicillin Y N Other

Please list additional drugs that cause allergic reactions:

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes, week #: _____ No

Are you nursing? Yes No

Have you experienced the following diseases or medical conditions?

- | | | |
|-----------------------------|-------------------------------|--------------------------|
| Y N Abnormal Bleeding | Y N Emphysema | Y N Liver Disease |
| Y N Alcohol/Drug Abuse | Y N Epilepsy/Seizures | Y N Osteoporosis |
| Y N Anemia | Y N Fainting Spells | Y N Pacemaker |
| Y N Arthritis/Rheumatoid | Y N Frequent/Severe Headaches | Y N Persistent Cough |
| Y N Artificial Bones/Joints | Y N Glaucoma | Y N Psychiatric Problems |
| Y N Artificial Heart Valves | Y N Heart Attack | Y N Radiation Treatment |
| Y N Asthma | Y N Heart Murmur | Y N Sinus Problems |
| Y N Blood Transfusion | Y N Heart Surgery | Y N Steroid Therapy |
| Y N Cancer | Y N Hepatitis Type _____ | Y N Stroke |
| Y N Chemotherapy | Y N Herpes/Fever Blisters | Y N Thyroid Problems |
| Y N Colitis/Ulcers | Y N High/Low Blood Pressure | Y N Tuberculosis (TB) |
| Y N Congenital Heart Defect | Y N HIV+/AIDS | Y N Venereal Disease |
| Y N Diabetes A1C _____ | Y N Infective Endocarditis | |
| Y N Difficulty Breathing | Y N Kidney Problems | |

Please list any hospitalizations or major surgeries in the last five years: _____

List any serious medical condition(s) that you have experienced: _____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of Patient, Parent or Guardian: _____ Date: _____

HEALTH HISTORY