



Name: _____ Preferred: _____ Consent Date: _____

Email Address _____

Address: _____ City _____ ST _____ Zip _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Marital Status: Married Single Divorced Separated

Employer: _____ Do you have dental insurance? YES NO

Employer Address: _____

Date of Birth: _____ Social Security # _____

How did you hear about our practice? _____

- Yes No Have you been a patient in the hospital during the last two years?
- Yes No Have you been under care of a medical doctor during the past two years?
- Yes No Have you ever had any excessive bleeding requiring special treatment?
- Yes No Are you allergic to (i.e., itching, rash, swollen hands, feet, or eyes) or made sick by penicillin or latex?
- Yes No Do you have shortness of breath, chest pain, or get extremely tired when walking up one flight of stairs?
- Yes No Do your ankles swell up during the day?
- Yes No Do you smoke? If so, how many packs a day? _____
- Yes No WOMEN: Is there a possibility you are pregnant now?
- Yes No Do you snore?
- Yes No Do you have daytime sleepiness?

Please circle the following medication that you have taken in the past two years:

| | | | |
|----------------|-----------------|------------------------|---------------------|
| Anticoagulants | Aspirin | Nitroglycerin | Cortisone medicine |
| Antihistamines | Antidepressants | Anti-hypertensive Meds | Diuretics |
| Insulin | Chemotherapy | X-ray/Cobalt Therapy | Contraceptive Pills |
| Phen-Fen | Fosamax | Arthritic Medication | St. John's Wort |

Please list all medications taken (include supplements):

Have you ever had any of the following?

| | | | |
|-----------------------------------|--------------------------------|-------------------------------|------------------------------|
| Yes No Heart Disease or Attack | Yes No High Blood Pressure | Yes No Venereal Disease | Yes No Fainting/Dizzy Spells |
| Yes No Cancer or Leukemia | Yes No Bruise Easily | Yes No Sleep Apnea | Yes No Epilepsy or Seizures |
| Yes No Heart Murmur | Yes No Tumors | Yes No Thyroid Disease | Yes No COPD/Emphysema |
| Yes No Artificial Heart Valve | Yes No Arthritis or Rheumatism | Yes No Hepatitis | Yes No Hay Fever |
| Yes No Congenital Heart Disease | Yes No Pain in Jaw Joints(TMJ) | Yes No Persistent Cough | Yes No Allergies or Hives |
| Yes No Implants(Joint/Knee, etc.) | Yes No Liver Disease | Yes No Tuberculosis (TB) | |
| Yes No Kidney Trouble | Yes No HIV or AIDS | Yes No Asthma | |
| Yes No Heart Pacemaker | Yes No Diabetes | Yes No Blood Transfusion | |
| Yes No Heart Surgery | Yes No Glaucoma | Yes No Hemophilia | |
| Yes No Angina Pectoris | Yes No Psychiatric Care | Yes No Drug/Alcohol Dependent | |
| Yes No Stroke | Yes No Frequent Cold Sores | Yes No Anemia | |

Do we have permission to contact your physician regarding items on this form or regarding any information that will aid us in your treatments? Yes No Physician's Name and Number: _____

To the best of my knowledge, all of the above answers are true and correct. If I ever have any change in my health condition, I will inform this office at the next appointment. I give my informed consent for the dental team to perform dental services

Date: _____ Signature: _____