**Patient Information:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any changes to your dental insurance coverage? Yes / No

If yes, please provide details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical and Dental History:**

Have you been hospitalized for any surgical operations or serious illness in the past year? Yes / No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medication(s) including non-prescription medicine? Yes / No

If yes, list medication and dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any health problems from last year that need further clarification? Yes / No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken any of the following (circle yes / no):

1. Fen-Phen/Redux Yes / No
2. Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes / No
3. Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes / No
4. Do you use controlled substances? Yes / No
5. Do you smoke, chew tobacco, or vape?Yes / No

Are you allergic to or have you had any reaction to the following medication (circle yes / no):

• Local Anesthetics Yes / No  • Penicillin, Tetracycline, or any other antibiotic Yes / No

• Sulfa Drugs  Yes / No • Aspirin Yes / No

• Codeine Yes / No • Metal Yes / No

• Sedatives Yes / No • Latex Yes / No

• Iodine Yes / No • Other (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Conditions (please circle any of the following that you have had or currently have):

• Allergies (pollen, dust) • Drug Addition • HIV/AIDS (circle)

• Anemia • Emphysema • Human Papillomavirus HPV

• Angina/Chest Pain • Epilepsy/Convulsions • Kidney Disease

• Anxiety/Nervous Disorder • Excessive/Abnormal Bleeding • Liver Disease

• Arthritis/Gout • Excessive Thirst • Mitral Valve Prolapse

• Artificial Heart Valve • Fainting/Seizures • Nursing

• Artificial Joint  • GI Disorders/Acid Reflux • Pneumonia

• Asthma • Glaucoma • Pregnant or Attempting

• Blood Pressure Low • Heart Attack/Failure • Taking Oral Contraceptives

• Blood Pressure High  • Heart Disease • Thyroid Problem

• Bone Disorders • Heart Murmur • Tuberculosis

• Cancer • Heart Pace Maker • Weight Loss (unexpected)

• Chemotherapy/Radiation • Hepatitis A, B, C (circle) • Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Diabetes • Herpes Simplex Type I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge and belief, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at my next appointment.

Patient or Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor/Hygienist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_