Brighten the World with your Smile

Confidential Patient Information

(PLEASE PRINT)

Date_____

Patient_____
Last Name **First Name** **Initial** **Preferred Name**

Are your address and phone number still the same as previously provided on your most recent medical history? **Yes** ☐ **No** ☐

Street Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Medical History

Physician's Name_____ Date of Last Physical_____

Are you allergic to: ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Latex

Do you have any other drug allergies or have had an adverse reaction to any medications? ☐Yes ☐No

If so, what?_____ Have you ever responded adversely to medical or dental treatment?_____

Please list ALL medications, pills, or drugs you are taking on the sheet provided (next page).

Are you taking any of the following medications? ☐Pre-medication before dental treatment ☐Antacids ☐Tagamet ☐Herbal Supplements ☐Warfarin or Coumadin ☐Other_____

Have you ever been treated with Bisophosphonate drugs? ☐Fosamax ☐Boniva ☐Actonel For how long?_____

Are you under the care of a physician? ☐Yes ☐No For what conditions?_____

Have you had any major operations? ☐Yes ☐No If yes, what?_____

Do you suffer from any disability? ☐Yes ☐No If yes, what?_____

Do you smoke? ☐Yes ☐No If patient is a child what is his/her weight?_____

(Women)

Do you suspect you are pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No Are you taking oral contraceptives? ☐Yes ☐No

Have you ever had any of the following? (Please check Yes or No)

Yes	No		Yes	No		Yes	No	
☐	☐	**Artificial Heart Valve**	☐	☐	**Artificial Joints/Hips/Knee**	☐	☐	**Hepatitis**
☐	☐	**Heart Murmur**	☐	☐	**Asthma**	☐	☐	**Liver Disease**
☐	☐	**Leaky Heart Valve**	☐	☐	**Shortness of Breath**	☐	☐	**Venereal Disease**
☐	☐	**Mitral Valve Prolapse**	☐	☐	**Fainting or Dizziness**	☐	☐	**Recent Weight Loss**
☐	☐	**Heart Attack**	☐	☐	**Stroke**	☐	☐	**Tuberculosis**
☐	☐	**Heart Pacemaker**	☐	☐	**Diabetes**	☐	☐	**Psychiatric Care**
☐	☐	**Heart Surgery**	☐	☐	**Kidney Trouble**	☐	☐	**Ulcers**
☐	☐	**Chest Pain**	☐	☐	**Chemotherapy/Radiation**	☐	☐	**Epilepsy or Seizure**
☐	☐	**Heart Stents**	☐	☐	**Rheumatic Fever**	☐	☐	**HIV Positive**
☐	☐	**High Blood Pressure**	☐	☐	**Irregular Heart Beat**	☐	☐	**AIDS**

Signature of person completing this form_____ Date_____

Relationship (if other than patient)_____