PATIENT INFORMATION

Name: Date:

Date of Birth: Sex: M/F Height: Weight:

Occupation: Employer:

SSN: Home #: Cell #:

Email:

Address: Zip Code

Emergency Contact: Relationship:

Home #: Cell #:

If you are completing this form for another person, what is your relationship to that person?

Whom may we thank for your referral?

MEDICAL HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health?..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on_____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition?_____
5. The name and address of my physician is:_____
6. Have you had any serious illness, operation or hospitalization within the past 5 years Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapyfor multiple myeloma or other cancers (Reclast, Fosamax, Actonel Boniva, Aredia or Zometa) ? ..... Yes No
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   If so, please list_____
   _____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur..... Yes No
    b. Rheumatic Heart Disease..... Yes No

c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No

1. Chest pain upon exertion?..... Yes No
2. Shortness of breath after mild exercise? ..... Yes No
3. Do your ankles swell?..... Yes No

d. Allergies ..... Yes No
e. Sinus trouble..... .....Yes No
f. Asthma or hay fever..... .....Yes No
g. Fainting spells or seizures .....Yes No
h. Diabetes.....Yes No
i. Hepatitis, jaundice or liver disease .....Yes No
j. Frequent or recurring mouth sores .....Yes No
k. Thyroid problems .....Yes No
l. Respiratory problems, emphysema, bronchitis, etc.....Yes No
m. Arthritis or painful, swollen joints including jaw joint (TMJ).....Yes No
n. Osteoporosis ....Yes No
o. Stomach ulcer or hyperacidity .... Yes No
p. Kidney trouble.....Yes No
q. Tuberculosis ....Yes No
r. Persistent cough or cough that produces blood .....Yes No
s. Persistent swollen neck glands..... Yes No
t. Low blood pressure .....Yes No
u. Epilepsy or neurological disorder.....Yes No
v. Cancer .....Yes No
w. Any disease, drug or transplant operation that has depressed your immune system Yes No

11. Have you had abnormal bleed..... Yes No
    a. Have you ever required a blood transfusion? ....Yes No
12. Do you have any blood disorder such as anemia?..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws?..... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs..... .....Yes No
    d. Barbiturates or sleeping pills.....Yes No
    e. Aspirin.....Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics.....Yes No
    h. Latex or rubber products..... ..... Yes No
    i. Other..... Yes No
16. Have you had any serious trouble associated with previous dental treatment?Yes No
    If so, explain:_____
17. Do you have any other condition or disease you think the doctor should know about? Yes No
    If so, explain:_____
18. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____

19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? .....Yes No

20. Are you wearing contact lenses?..... Yes No
21. Are you wearing removable dental appliances?..... Yes No
22. Do you wish to talk with the doctor privately about anything? ..... Yes No

23. Do you snore? …… ……...Yes No
24. Do you have sleep apnea?.....Yes No
25. Are you currently using a CPAP? ……Yes No

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

Active Tuberculosis ……...Yes No
Persistent cough greater than a 3 weeks duration …….....Yes No
Cough that produces blood ……. ……Yes No
Been exposed to anyone with tuberculosis …….. ……Yes No

Women

26. Are you pregnant or trying to become pregnant ..... Yes No
27. Do you have problems associated with your menstrual period? ..... Yes No
28. Are you nursing?..... Yes No
29. Are you taking birth control pills?..... Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date:_____ Patient's Signature:_____