

PATIENT INFORMATION

First Name	Last Name	Date of Birth	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mobile Phone #		Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>		
Emergency Contact Name	Emergency Contact Phone #		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PREFERRED PHARMACY

Pharmacy Name	Pharmacy Phone
<input type="text"/>	<input type="text"/>
Address	<input type="text"/>
<input type="text"/>	<input type="text"/>

DENTAL HISTORY

How fearful are you of dental treatment (10 being the most)?

<input type="text"/>	Have you ever had braces, or had your bite adjusted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had gum surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any dental implants in your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last deep cleaning <input type="text"/>

POLICY HOLDER

Insured First Name	Insured Last Name
<input type="text"/>	<input type="text"/>
Relation to Patient	Gender
<input type="text"/>	<input type="text"/>
Insured Social Security	Date of Birth
<input type="text"/>	<input type="text"/>

INSURANCE INFORMATION

Insurance Name <input type="text"/>	Ins Phone Number <input type="text"/>
Policy ID <input type="text"/>	Group Name <input type="text"/>
Group # <input type="text"/>	<input type="text"/>
Address <input type="text"/>	<input type="text"/>

I certify I have read and I understand the questions. I acknowledge my questions have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her team, responsible for any errors or omissions that I have made in the completion of this form.

I agree to receive SMS updates at the phone number provided above and understand that message frequency may vary. Msg & data rates may apply. Reply STOP to opt out.

If I have dental insurance, my signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

I hereby acknowledge a copy of the Notice of Privacy Practices has been made available to me (see form on website). I have been given the opportunity to ask any questions I may have regarding this Notice.

MEDICAL HISTORY**Patient Name:****Birth Date:**Are you in good health? Yes No Height _____ Weight _____ Are you under care of a physician? Yes NoAre you currently taking or planning to take antibiotics before dental treatment? Yes NoHave you been hospitalized in the past five years? Yes No Have you ever had general anesthesia? Yes NoHave you or your family had reactions to general anesthesia? Yes No Have you had the COVID vaccination? Yes NoAre you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years? Yes No**WOMEN ONLY****1-4 below for women only:**

(Note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? Yes No 2) Expected delivery date _____3) Are you nursing? Yes No 4) Are you taking birth control pills? _____ Yes No**ALLERGIES/REACTIONS**

YN	YN	YN	YN
<input type="checkbox"/> <input type="checkbox"/> Penicillin	<input type="checkbox"/> <input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> <input type="checkbox"/> Local anesthetic	<input type="checkbox"/> <input type="checkbox"/> Amoxicillin
<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics	<input type="checkbox"/> <input type="checkbox"/> Latex	<input type="checkbox"/> <input type="checkbox"/> Do you have any known allergies

Please list any allergies not listed above _____

MEDICAL CONDITIONS**Do you have, or have you had, any of the following diseases, medical conditions, or procedures?**

YN	YN	YN	YN
<input type="checkbox"/> <input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> <input type="checkbox"/> Dementia	<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> Prosthetic implant
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> High cholesterol	<input type="checkbox"/> <input type="checkbox"/> History of Radiation
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Do you smoke or vape	<input type="checkbox"/> <input type="checkbox"/> History of alcohol / drug abuse	<input type="checkbox"/> <input type="checkbox"/> Respiratory problems
<input type="checkbox"/> <input type="checkbox"/> Arthritis / Joint disease	Number of smoke/day _____	<input type="checkbox"/> <input type="checkbox"/> History of marijuana / drug use	<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Do you use chewing tobacco	<input type="checkbox"/> <input type="checkbox"/> Infectious mononucleosis	<input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> <input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> <input type="checkbox"/> Sleep apnea / CPAP
<input type="checkbox"/> <input type="checkbox"/> Blood transfusion	<input type="checkbox"/> <input type="checkbox"/> Eye disease / Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Joint replacement	<input type="checkbox"/> <input type="checkbox"/> Special diet
<input type="checkbox"/> <input type="checkbox"/> Bronchitis	<input type="checkbox"/> <input type="checkbox"/> Fainting spells	<input type="checkbox"/> <input type="checkbox"/> Kidney trouble	<input type="checkbox"/> <input type="checkbox"/> Stomach ulcers / acid reflux
<input type="checkbox"/> <input type="checkbox"/> Bruise easily	<input type="checkbox"/> <input type="checkbox"/> Hayfever / Sinus problems	<input type="checkbox"/> <input type="checkbox"/> Liver disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Heart attack(s)	<input type="checkbox"/> <input type="checkbox"/> Low blood pressure	<input type="checkbox"/> <input type="checkbox"/> Thyroid trouble
<input type="checkbox"/> <input type="checkbox"/> Chest pain / Angina	<input type="checkbox"/> <input type="checkbox"/> Heart murmur	<input type="checkbox"/> <input type="checkbox"/> Low blood sugar	<input type="checkbox"/> <input type="checkbox"/> Trouble climbing 1-2 flights of stairs
<input type="checkbox"/> <input type="checkbox"/> Chronic cough	<input type="checkbox"/> <input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> <input type="checkbox"/> Mental health problems	<input type="checkbox"/> <input type="checkbox"/> Tumor or growth
<input type="checkbox"/> <input type="checkbox"/> Chronic fatigue / Night sweat	<input type="checkbox"/> <input type="checkbox"/> Heart surgery	<input type="checkbox"/> <input type="checkbox"/> Osteopenia	
<input type="checkbox"/> <input type="checkbox"/> Convulsions / Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Heart trouble	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> <input type="checkbox"/> COVID-19	<input type="checkbox"/> <input type="checkbox"/> Heart valve issues	<input type="checkbox"/> <input type="checkbox"/> Pneumonia	
<input type="checkbox"/> <input type="checkbox"/> Delay in healing	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Problems with immune system	

Any other medical conditions not listed above _____

MEDICATIONS**Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):**

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

PATIENT SIGNATURE

X

X

Signature of patient

Date

DOCTOR'S NOTES

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X

X

Signature of dentist

Date