

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"/>	
Address			
<input type="text"/>			
Emergency Contact Name		Emergency Contact Phone #	
<input type="text"/>		<input type="text"/>	

PREFERRED PHARMACY

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

DENTAL HISTORY

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

Have you ever had gum surgery? ☐ Yes ☐ No

Do you have any dental implants in your mouth? ☐ Yes ☐ No

Have you ever had braces, or had your bite adjusted? ☐ Yes ☐ No

Have you ever had deep cleaning of your teeth? ☐ Yes ☐ No

Date of last deep cleaning

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"/>	
Policy ID	Ins Phone Number
<input type="text"/>	<input type="text"/>
Group #	Group Name
<input type="text"/>	<input type="text"/>
Address	
<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 COMD 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, Redast, 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"/> Hay fever / 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

X

X

Signature of dentist

Date