dental excellence

Office use:
Scanned _____
Updated _____

Date: _____

Name: _____

How did you hear
about our office?_____

Date of birth:_____

Address:_____

City, State & Zip:_____

Social Security No:_____

Home phone:_____

Cell phone:_____

E-Mail address:_____

Reminder for appt (check all that apply):
___Phone ___Text ___ E-mail____

Occupation:_____

Employer:_____

Work Phone:_____

Marital Status:
Married: ☐ Single: ☐
Divorced: ☐ Widowed: ☐

Spouses name:_____

Children's names and ages:_____

Who may we contact in case of emergency:
Name_____
Telephone:_____
Relationship:_____
Physician's name:_____
When was your last cleaning?_____

	YES	NO
Are you now or have you ever taken oral Bisphosphonate medications including Fosamax, Actonel or Boniva?	☐	☐
If yes, have you received:		
*Past or current chemotherapy	☐	☐
*The intravenous medications Zometa, Aredia or Bonefos	☐	☐

To the best of your knowledge, have you ever been diagnosed with:	Y	N
Snoring or sleep apnea ----------	☐	☐
If yes, do you have a CPAP machine	☐	☐
Chest pains----------	☐	☐
Heart Attack/ heart stents----------	☐	☐
Mitral Valve Prolapse----------	☐	☐
Pacemaker----------	☐	☐
Heart Murmur----------	☐	☐
Stroke----------	☐	☐
Diabetes----------	☐	☐
☐ Type 1 ☐ Type 2 Last A1C_____		
Rheumatic fever----------	☐	☐
Epilepsy----------	☐	☐
High Blood Pressure----------	☐	☐
Asthma----------	☐	☐
COPD----------	☐	☐
Emphysema----------	☐	☐
TB----------	☐	☐
Hepatitis----------	☐	☐
Prolonged bleeding, healing complications	☐	☐
Thyroid Problems----------	☐	☐
Glaucoma----------	☐	☐
Joint replacement or implant----------	☐	☐
If yes, have you ever been told you need a pre-medication before dental procedures? ----------	☐	☐
Arthritis----------	☐	☐
Acid reflux or eating disorder---------	☐	☐
AIDS (HIV)----------	☐	☐
Cancer----------	☐	☐
If yes, what type_____		
Are you currently being treated	☐	☐
Are you pregnant or think you may be pregnant?-	☐	☐
Do you smoke or use tobacco----------	☐	☐
History of or current drug use----------	☐	☐

Are you or have you ever been allergic to:		
Local anesthetics (Novacaine).-------	☐	☐
Penicillin or other antibiotics---------	☐	☐
Sedatives (Valium)----------	☐	☐
Aspirin----------	☐	☐
Ibuprofen----------	☐	☐
Tylenol----------	☐	☐
Any metals----------	☐	☐
Latex----------	☐	☐

Any other conditions or allergies you may have?_____

Please list any medications you are currently taking:____
_____
_____
_____