Personal Information

Surname: _____ First Name: _____

Address: _____

City: _____ Postal Code: _____

Birth Date: _____

Home Phone: _____ Other Phone: _____

E-mail: _____ Employer: _____

Preferred method of contact (Please Circle): Text Email Call

Insurance Information

Provider: _____

Group #: _____ ID #: _____

Medical History Signature:_____ Date:_____

Do you have any concerns about receiving dental treatment?

Are you being treated for any kind of condition by a Physician now?

Have you ever had a serious illness or accident?

Have you had any of the following medical conditions?

Hepatitis A B C ----Circle			Kidney/Liver Disease	____Y	____N
HIV/AIDS	____Y	____N	Stroke	____Y	____N
Inflammatory Rheumatism	____Y	____N	Arthritis	____Y	____N
Diabetes	____Y	____N	Asthma	____Y	____N
Heart Attack	____Y	____N	Epilepsy	____Y	____N
Cancer or Tumor	____Y	____N	High Blood Pressure	____Y	____N
			Low Blood Pressure	____Y	____N

Do you have any allergies?

Have you ever had an unusual reaction to any of the following drugs?

Local Anesthetic	___Y ___N		
Penicillin	___Y ___N	Sulfa	___Y ___N
Iodine	___Y ___N	Other	_____

Do you bleed excessively when cut?

Are you taking any medication now? Y / N (If Yes, please list) _____

Have you ever taken medication for osteoporosis?

Do you take blood thinners?

Have you ever had radiation to your head and/or neck?

Do you have any special instructions from a physician regarding pre- medication for dental work?

Do you smoke?

What is your daily oral hygiene routine?

(WOMEN) Are you pregnant at the present time? ___Y ___N Expected Due Date_____