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**Patient Information**

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**FName:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **LName:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_ **Soc Sec #:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Text reminders? Yes / No**

**Email:** \_\_\_\_\_ **Email reminders? Yes / No**

**Preferred Contact Method:** Home   Cell   Email Text   Other: \_\_\_\_\_

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**Responsible Person (if under 18):**

**FName:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **LName:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Address (if different):** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

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**Insurance Information:**

**Do you have Dental Insurance: Yes / No?**

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**Emergency Contact Information:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

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**Name of your previous Dentist:** \_\_\_\_\_ **Last Visit:** \_\_\_\_\_

**Main Dental Concerns:** \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

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Do you have or have you ever had any of the following?

Arthritis	Angina	<b>ALLERGY TO:</b>
Joint Replacement/Implant	Artificial Heart Valve	Ibuprofen
Organ Transplant	Heart Attack	Aspirin
Asthma - Inhaler <b>Yes or No</b>	Heart Lesions	Tylenol
Emphysema	Heart Murmur	NSAIDS
Respiratory Problems	High Blood Pressure	Penicillin
Easily Winded	Low Blood Pressure	Amoxicillin
Hay Fever/Allergies	Mitral Valve Prolapse	Tetracycline
Chew/Smoke Tobacco	Pacemaker	Erythromycin
Cold Sores/Herpes	Rheumatic Fever	Zithromax
Glaucoma	Heart Disease	Azithromycin
Stroke	Chest Pains	Hydrocodone
Epilepsy	Anemia	Codiene
Dizziness	Hemophilia	Morphine
Fainting	Blood Disease	Barbituates
Head Injuries	Blood Transfusion	Sedatives
Mental Disorders	Blood Clots	Local Anesthetics
Drug/Alcohol Addiction	Excessive Bleeding	Iodine
Kidney Disease	Pain/Noise in Jaw Joints	Sulfa Drugs
Diabetes	Pregnancy: <b>Past or Present</b>	Metals
Liver Disease	Thyroid Problems	Latex Rubber
Jaundice	Frequently Tired	NONE
Hepatitis - <b>A B or C</b>	Recent Weight Loss	Others List Below
Aids/HIV	Swollen Ankles	
Venereal Disease	Stomach Problems	
Sexually Transmitted Diseases	Ulcers	
Cancer	Radiation Treatment	
Growths/Tumors	Chemotherapy	
Leukemia	Other:	
Tuberculosis	None	

Have you taken any bone density medications such as Fosamax, Boniva or another such as these? **Yes / No** If yes, which medication? \_\_\_\_\_

Current Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Have you ever been instructed to take an antibiotic **PREMED** for Dental treatment? **Yes / No**

Current Medications: \_\_\_\_\_

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