New Patient Personal and Medical History

Name:_____ Date:_____/_____/_____

Address:_____ City:_____ Zip:_____

Hm Phone:_____ Work:_____ Cell:_____

DOB:_____/_____/_____ Social Security #_____-_____-_____ Marital Status: S___M___D___W___P___

Email:_____

Employer:_____ Occupation:_____

Emergency Contact:_____Phone:_____Relationship:_____

MEDICAL HISTORY: Physician's Name:_____

Are you currently undergoing any medical treatment or seeing a physician for a particular problem?**No___Yes___**
If yes, please explain:

Have you had any hospitalizations or surgeries in the past year? **No____ Yes____**If so, please explain:

Please list any prescription medications you are taking:

Please list any over-the-counter medications or herbal products you are taking:

Have you ever taken Fosamax, Boniva, Actonel or any medications containing Bisphosphonates? **No____ Yes____**
If Yes, please explain

Are you allergic to or have you had a bad reaction to any medications or products below:
Aspirin_____ Penicillin_____ Codeine_____ Local Anesthetics_____ Acrylic _____ Metal_____ Latex_____
Sulfa drugs_____ Iodine_____ Sedatives_____
Food:_____Other:_____

Do you smoke or use any smokeless tobacco products? Yes _____ No _____ How long have you?_____
Have you smoked in the past? Yes ____ No ____ If Yes, how long did you? _____ and when did you quit?_____

Do you, or have you used controlled substances or other recreational drugs? _____YES _____ NO
Please explain: **OVER>>>>**

Women: Are you currently pregnant or trying to get pregnant?_____ # of weeks?_____
Are you experiencing any symptoms of menopause or premenopause? Yes _____ No_____

DO YOU or HAVE YOU had any of the following: (Please check all that apply)

_____HIV/AIDS <-(*Circle One*)
_____Alzheimer's Disease
_____Anaphylaxis to _____
_____Anemia
_____Angina
_____Arthiritis/Gout
_____Artificial Heart Valves
*Date*____/____/_____
_____Artificial Joint replacement
~Hip/Knee~ (circle)
*Date*____/_____/_____
_____Asthma
_____Blood Transfusion
_____Breathing Problems
_____Bruise Easily
_____Cancer
_____Chemotherapy
_____Chest Pains
_____Cold Sores/Herpes(*Circle one)*
_____Congenital Heart Disorder
_____Cortisone Medicine
_____Diabetes
_____Drug Addiction
_____Easily Winded
_____Emphysema
_____Epilepsy/Seizures
_____Excessive Bleeding
_____Excessive Thirst
_____Fainting Spells
_____Frequent Headaches
_____Genital Herpes
_____Hay Fever/Seasonal Allergies
(*Circle One*)
_____Heart Attack/Failure
*Date*_____/_____/_____
_____Heart Murmur
_____Heart Pacemaker-
*Date*_____/_____/_____
_____Heart Trouble/Disease
_____Hemophilia
_____Hepatitis A
_____Hepatitis B or C
_____High Blood Pressure
_____High Cholesterol
_____Hives or Rash
_____Hypoglycemia
_____Irregular Heartbeat
_____Kidney problems/Disease
_____Leukemia
_____Liver Disease
_____Low Blood Pressure
_____Lung Disease
_____Mitral Valve Prolapse
_____Osteoporosis
_____Pain in Jaw Joints
_____Parathyroid Disease
_____Psychiatric Care
_____Radiation Treatments
_____Recent Weight Loss
_____Renal Dialysis
_____Rheumatic Fever
_____Rheumatism
_____Scarlet Fever
_____Shingles
_____Sickle Cell Disease
_____Sinus Trouble
_____Stomach/Intestinal Disease
_____Stroke
*Date*____/_____/_____
_____Swelling of Limbs
_____Thyroid Problems/Disease
_____Tonsillitis
_____Tumors or Growths
_____Ulcers
_____Yellow Jaundice

IN ADDITION…DO YOU HAVE OR HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING?: (Please check all that apply)

_____ADD/ADHD
_____Anorexia _____Bulemia
_____Autism
_____Bells Palsy
_____Blood disease
_____Bone Disorder
_____COPD
_____Crohn's Disease
_____Previous Bacterial Heart Infection
_____Hormone Replacement Therapy
_____Human Papilloma Virus (HPV)
_____Shunt placed – *Date*____/____/_____
_____Lupus

TELL US ABOUT YOUR TEETH…

Do you have sensitivity to hot/cold? Yes ____No ____ Do you have any chewing pain? Yes ____ No_____
Have you had any head, neck, or jaw injuries? Yes ___No____ Explain if yes_____
Does your jaw hurt when you open/close your mouth? Yes ____No____ Explain if yes_____
Does it click, pop, or lock? Yes ____No____ Explain if yes_____
Are you interested in Tooth Whitening?_____
ANY OTHER DENTAL CONCERNS YOU HAVE OR WORK YOU WANT COMPLETED?

Authorization and Release:

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practioners. I agree to be responsible for payment of all services rendered on my behalf or my independents.

X_____ _____/_____/_____
Signature of patient or parent if minor **Date**