Patient Name ________________________________

Date of Last Dental Visit:______________________

Please check all that apply:

□ **(Allergies)**
- □ Nickel
- □ Codeine
- □ Penicillin
- □ Latex
- □ Ibuprofen
- □ Aspirin
- □ Sulfa
- □ Anesthetic
- □ Gluten

Other allergies_______________

(Conditions)
- □ Anemia
- □ Alcohol/Drug □ Dependency
- □ Arthritis
- □ Artificial Joints
- □ Anxiety
- □ Asthma
- □ Bleeding Gums
- □ Blood Disease
- □ Cancer
- □ Cannabis use
- □ Diabetes
- □ Dizziness
- □ Depression
- □ Emphysema
- □ Epilepsy
- □ Excessive Bleeding
- □ Fainting
- □ Glaucoma
- □ Growths/Tumors
- □ Hay Fever
- □ Head/Neck Injuries
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis A, B or C
- □ High Blood Pressure
- □ High Cholesterol
- □ HIV/ AIDS
- □ Kidney Disease
- □ Liver Disease
- □ Low Blood Pressure
- □ Mental Disorders
- □ Nervous Disorders
- □ Osteoporosis medications (*Fosamax etc.*)
- □ Pacemaker
- □ **Currently** Pregnant (Due date):__________
- □
- □ Respiratory Problems
- □ Rheumatic Fever
- □ Rheumatism
- □ Sinus Problems
- □ Smoker/Oral tobacco use?
- □ Stomach or duodenal Ulcers
- □ Stroke-Date ______________
- □ Thyroid
- □ Tuberculosis
- □ Viral Infections/Cold Sores
- □ Sleep Apnea
- □ CPAP Machine Use Start Date of Use ___________
- E Cigarette/ Vapor use

Other Conditions not listed____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:______________________________________

____

DO YOU HAVE ANY OF THE FOLLOWING (please circle):
- ○ Artificial Heart Valve
- ○ History of Infective Endocarditis
- ○ Congenital (present from birth) Heart Condition
- ○ Cardiac Transplant That Develops a Heart Valve Condition
- ○ Joint Replacement (date of surgery)_________________

Do you need to take a Pre-Medication (Antibiotic) prior to dental visits?:___________________________
Name of Physician/ Orthopedic Surgeon________________________(**Location**)_____________________
Phone:# ____________________________

- Have you ever had any complications following dental treatment? □ Yes □ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No
  If yes, please explain: ____
- Are you now under the care of a physician? □ Yes □ No
  If yes, please explain: ____

____ ________________________
Signature of patient, parent or guardian **Date**
Relationship to Patient_________________________

Patient Information

Patient Name: ________________________________ Preferred Name)______________________ Date______________

Address: ____
Street Apartment #

____
City State Zip Code

Social Security #: ______________________________ **Birth Date:** ______________

Phone (Home):________________ **(Work):** ____________ **(Cell)** ________________

Can we text or email you appt. reminders?______________ **Email**______________________

Emergency Contact:______________________________ **Phone#:**______________________

How did you find out about our office?____

- (Guardian or Parent for a Minor Child)

Name: ____________________________________ **Relationship to Patient:** ______________

▫ **Male** ▫ **Female** **SSN #:**______________________ **Birth Date:** ______________

(Home#):________________ **(Work#):** __________________ **(Cell#)** ____________________

Address: ____
Street Apartment #

____
City State Zip Code

Dental Insurance Information (Please complete)

Primary Dental Insurance

Subscriber: ________________________________ **Employer Name:** ______________________

Insured's Birth Date: ______________ **SSN#**__________________ **Group #:** ______________

Insurance Plan Name:____________________________________ Phone #: ______________

Claims Mailing Address:____

Secondary Dental Insurance

Subscriber________________________________ **Employer Name:** ______________________

Insured's Birth Date: ______________ **SSN #:** __________________ **Group #:** ______________

Insurance Plan Name:____________________________________ **Phone #:** ______________

Claims Mailing Address:____