



PATIENT INFORMATION FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):	<input type="checkbox"/> M <input type="checkbox"/> F	Today's Date:
Birth Date:	Email:	
Address:		
Primary Phone:	Secondary Phone:	
I prefer to be contacted by email phone text		
In case of emergency please contact:		Phone:
Who may we thank for referring you?		

Dental Insurance Subscriber:	Company:	ID # or SS#
Reason for today's appointment:		
When was your last dental exam?		
Bleeding gums or sensitive teeth?		

MEDICAL INFORMATION	
Are you under a physician's care now? Yes No If yes, please explain:	
Do you use tobacco? Yes No	Do you use controlled substances? Yes No
Do you need to pre-medicate? Yes No	
Have you ever had a serious head or neck injury? Yes No If yes, please explain:	Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Women only	Any possibility of pregnancy?
	Expected delivery date?
	Nursing?
	Taking birth control?

MEDICATION HISTORY			
Are you now taking or have taken:			
Nerve pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Killers (including Aspirin) <input type="checkbox"/> Yes <input type="checkbox"/> No	Stimulants <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Relaxers <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers <input type="checkbox"/> Yes <input type="checkbox"/> No	Antidepressants <input type="checkbox"/> Yes <input type="checkbox"/> No
Any bone density medications (Boniva, Fosamax, Actonel)		<input type="checkbox"/> Yes <input type="checkbox"/> No	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Are you allergic to or had a reaction to:

Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valium or other tranquilizers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Soy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine or other narcotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfites	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH HISTORY

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A, B, C	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High or Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any Joint replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer or Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Following Questions refer to your sleeping patterns:	
Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use a CPAP machine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been told you snore during sleep or ever wake yourself from snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you stop breathing at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a history of nodding off at inappropriate times or places?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you often wake in the morning feeling sleepy tired or unrefreshed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low or High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches when you wake up in the morning?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Getting up to go to the bathroom in the middle of the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use medications to help you sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

Reviewed by Dr. _____	Date _____
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