## About you:

**Name:** _____
Last First MI
**Address:**_____
_____
City State ZIP
**Social Security #:**_____
**Birthdate: ____/____/_____** ☐M ☐F
**Home Phone: (_____) _____:_____**
**Cell Phone: (_____) _____:_____**

**Employer:** _____
**Occupation:** _____
**Social interest or Hobbies:** _____
☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed**
**Referred by:** _____

**In case of emergency, is there someone we can contact?**
**Name:** _____
**Relationship:** _____
**Phone number: (_____) _____:_____**

## Medical History:

Do you have a personal doctor ☐Yes ☐No
Their name: _____
Approx. date of your last doctor visit: _____
Are you currently under care of a Doctor ☐Y ☐N
Do you smoke or use tobacco in any form: ☐Y ☐N
Are you pregnant? ☐Y ☐N
Area of joint replacement(s) and Date: _____

**Please provide a current medication list:**

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase or other diabetes drug
- ☐ Nitroglycerine
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other

## Have you ever had any of the following Diseases or medical problems?

Y N Heart attack/stroke
Y N Heart murmur/Rheumatic fever/Mitral Valve Prolapse
Y N Chronic hepatitis or Tuberculosis
Y N High/low blood pressure
Y N Severe headaches/migraines
Y N Epilepsy/seizures/ fainting spells
Y N Drugs/ Alcohol abuse/ Psychiatric problems
Y N Hemophilia/ Abnormal bleeding
Y N Cancer/ Chemotherapy
Y N HIV+/Aids
Y N Shingles
Y N Kidney Problems
Y N Sinus Problems
Y N Diabetes

## Dental History:

Why have you come to the dentist today?
_____
_____

Are you currently in pain? ☐Y ☐N
Do you experience stress/anxiety when at the dentist? ☐Y ☐N
Do you like to use Nitrous Oxide? ☐Y ☐N
Approx. date of last dental visit? _____
Do you grind your teeth? ☐Y ☐N
Do you like your smile? ☐Y ☐N
Do your gums ever bleed? ☐Y ☐N
Do you want to prevent dentures? ☐Y ☐N

## Are you allergic to any of the following?

Y N Penicillin
Y N Erythromycin
Y N Dental anesthetics
Y N Codeine
Y N Aspirin
Y N Tetracycline
Y N Sulfa
Y N Latex
Other: _____

*I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes to my medical status.*

_____ _____
Signature Date