PATIENT INFORMATION

Health Alert	Allergies	Premed

Name

DOB

Mailing Address

Postal Code

(   )

(   )

(   )

Phone

Work

Cell

Email

Medical doctor

Number

Emergency contact

Number

Relationship

Pharmacy

Number

I understand and accept that by refusing x-rays, diagnosis of dental decay, periodontal disease or dental infections may be delayed and could potentially lead to complications not limited to, but including bone and tooth loss.

Initials

I consent to the following electronic messages for appointment confirmation and office communications: ◯ e-mail ◯ text messages

As part of record keeping and documentation we may use digital photographs and/or video.

Signature

Date

Occupation

Guardian (if minor)

PATIENTS WITH DENTAL INSURANCE ONLY:

Insurance Company name

Policy holders name

DOB

Employer

Policy / group #

Certifi / ID #

DO YOU HAVE SECONDARY INSURANCE?

Insurance Company name

Policy holder name

DOB

Employer

policy / group #

certifi / ID #

HEALTH HISTORY

Please be as accurate as possible, all information is confidential, and gathered only to provide you the best care possible.

Please list any medications you are currently taking (including over the counter).

Medication	Condition

Have you ever taken bisphosphonates? *(for osteoporosis)*

Check ☑ any of the following which you have had or have at present

- ○ Heart disease / angina
- ○ Stroke
- ○ High blood pressure
- ○ Diabetes
- ○ Liver disease
- ○ Hepatitis A, B or C
- ○ Kidney disorder
- ○ Respiratory disorder
- ○ HIV+ / AIDS
- ○ Psychiatric disorder (if yes specify)
- ○ Pain in Jaws (TMD)
- ○ Arthritis
- ○ Stomach/GI disorder
- ○ Joint replacement
- ○ Artificial heart valve
- ○ History of infective endocarditis
- ○ Congenital heart defect
- ○ Cardiac transplant
- ○ Cancer / chemo / radiation therapy
- ○ Bleeding disorder
- ○ Epilepsy/seizures
- ○ Alcohol / drug addiction
- ○ Mobility restrictions specify:
- ○ Asthma

Please specify if you have allergies to the following:

- ○ Metals *(jewelry)*
- ○ Local anesthetics
- ○ Latex rubber
- ○ Penicillin or other antibiotics *(Please specify)* ______________________
- ○ Other medications *(Specify)* ______________________
- ○ Foods *(Specify)* ______________________
- ○ Do you use tobacco? *(If yes for how long)* ______________________
- ○ Women only: are you pregnant?__________ # of weeks __________