New Patient Contact Information

Please read the following questions carefully and answer COMPLETELY.

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.

Legal Name ___________________________________ Circle one: Mr. Mrs. Ms. Miss Dr.

Preferred Name ________________________________

Birthdate _____ / _____ / ______ Age _____ Social Security # _________________

Did anyone refer you to our office? ______________________________

Have you been to a dentist in the last 2 years? If so, who? _____________________________

May we contact them for your records and x-rays? _____________________________

How would you like your appointments confirmed? Circle one: Phone Call Text Email

Primary Phone __________________________________ Circle one: Cell Home Work

Secondary Phone __________________________________ Circle one: Cell Home Work

Street Address ____

City ____________________ State ____ Zip _________

Email __________________________________

Employer __________________________________

Employer Phone _____________________

Local Emergency Contact ______________________________

Relationship_____________________ Phone _____________________

To the best of my knowledge, the information on this form is correct.
I understand that providing incorrect information can be dangerous to my health.

Patient (or Parent/Guardian) Signature _______________________ Date ____________

Patient Medical History

Name ____________________________ *Circle one* *If yes, please explain*

Question	Circle one		If yes, please explain
Are you under a doctor's care?	No	Yes	__________________
Have you ever been hospitalized or had a major operation?	No	Yes	__________________
Have you ever had a serious head or neck injury?	No	Yes	__________________
Are you taking any medications, pills, or drugs?	No	Yes	__________________
Do you take, or have you taken, Phen-Fen or Redux?	No	Yes	__________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	No	Yes	__________________

Are you on a special diet?	No	Yes	Are you pregnant, trying to become pregnant, or nursing?	No	Yes
Do you use tobacco?	No	Yes			
Do you use controlled substances?	No	Yes	Are you taking oral contraceptives?	No	Yes

Are you **allergic** to any of the following? Circle all that apply.

Aspirin	Penicillin	Codeine	Acrylic	Metal	Latex
Sulfa drugs	Local Anesthetics	Dairy	Other ______________________		

Do you have, or have you had any of the following? Circle all that apply.

AIDS/HIV positive	Bruising Easily	Rheumatism	Tumors or Growths	Asthma
Radiation Treatments	Swelling of Limbs	High Cholesterol	Cold Sores/ Fever blisters	Sinus Trouble
Hepatitis A	Lung Disease	Excessive Bleeding		Kidney Problems
Drug Addiction	Hay Fever	Artificial Joint	Parathyroid Disease	Frequent Diarrhea
Anemia	Chest Pains	Sickle Cell Disease	Heart Trouble/Disease	Breathing Problems
Rheumatic Fever	Tuberculosis	Irregular Heartbeat	Yellow Jaundice	Stroke
High Blood Pressure	Pain in Jaw Joints	Frequent Cough	Hemophilia	Low Blood Pressure
Epilepsy or Seizures	Pacemaker	Blood Transfusion	Diabetes	Glaucoma
Artificial Heart Valve	Convulsions	Gastrointestinal Disease	Anaphylaxis	Chemotherapy
Shingles	Venereal Disease		Renal Dialysis	Tonsillitis
Hypoglycemia	Cortisone Medicine	Liver Disease	Herpes	Osteoporosis
Dizziness/Fainting	Alzheimer's Disease	Genital Herpes	Emphysema	Heart Murmur
Blood Disease	Recent Weight Loss	Cancer	Arthritis/Gout	Congenital Heart Disorder
Spina Bifida	Hepatitis B or C	Thyroid Disease	Scarlet Fever	
Leukemia	Easily Winded	Mitral Valve Prolapse	Hives or Rash	Ulcers
Frequent Headaches	Angina	Heart Attack/Failure	Excessive Thirst	Psychiatric Care

Have you had any serious illness not listed above? If so, please explain. __________________

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 health.

Patient (or Parent/Guardian) Signature ______________________ Date ____________