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.

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

Preferred Name (if any) ________________________ Marital Status ____________________

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

Who may we thank for referring you to us? _______________________________

Have you been to a dentist in the last 5 years? If so, who? ______________________________

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

Primary Phone __________________________________ Circle one: Cell Home Work

Secondary Phone __________________________________ Circle one: Cell Home Work

Street Address ____

City _____________________ State ____ Zip __________

Email __________________________________

Employer __________________________________ Phone # ______________________

Local Emergency Contact _______________________________

Relationship______________________ Phone ______________________

If you carry dental insurance, please present your card to the front desk.

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 describe***

Do you see a doctor regularly? 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: _______________________

What medications, pills, or drugs do you take? _________________________________

Have you ever 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

Do you use tobacco? No Yes

Do you use controlled substances? No Yes

Are you pregnant, trying to become pregnant, or nursing? 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 _____________		None

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

AIDS/HIV positive	Bruising Easily	Rheumatism	Tumors or Growths	Sinus Trouble
Radiation Treatments	Swelling of Limbs	High Cholesterol	Cold Sores	Kidney Problems
Hepatitis A	Lung Disease	Excessive Bleeding	Parathyroid Disease	Frequent Diarrhea
Drug Addiction	Hay Fever	Artificial Joint	Heart Trouble/Disease	Breathing Problems
Anemia	Chest Pains	Sickle Cell Disease	Yellow Jaundice	Stroke
Rheumatic Fever	Tuberculosis	Irregular Heartbeat	Hemophilia	Low Blood Pressure
High Blood Pressure	Pain in Jaw Joints	Frequent Cough	Diabetes	Glaucoma
Epilepsy or Seizures	Pacemaker	Blood Transfusion	Anaphylaxis	Chemotherapy
Artificial Heart Valve	Convulsions	Gastro. Disease	Renal Dialysis	Tonsillitis
Shingles	Venereal Disease	Sleep Apnea/Snoring	Herpes	Osteoporosis
Hypoglycemia	Cortisone Medicine	Liver Disease	Emphysema	Heart Murmur
Dizziness/Fainting	Alzheimer's Disease	Genital Herpes	Arthritis/Gout	Congenital Heart
Blood Disease	Recent Weight Loss	Cancer	Scarlet Fever	Disorder
Spina Bifida	Hepatitis B or C	Thyroid Disease	Hives or Rash	Ulcers
Leukemia	Easily Winded	Mitral Valve Prolapse	Excessive Thirst	Psychiatric Care
Frequent Headaches	Angina	Heart Attack/Failure	Asthma	None of the Above

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 ____________