

PATIENTS'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

PATIENT'S SS# \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

NAME OF FAMILY DENTIST \_\_\_\_\_ DATE OF LAST CLEANING \_\_\_\_\_

NAME OF YOUR PHYSICIAN \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME OF EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_

ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle)

- |              |                              |              |                   |
|--------------|------------------------------|--------------|-------------------|
| Aspirin      | Iodine                       | Thorazine    | Biaxin            |
| Codeine      | Local Anesthetic             | Probanthine  | Cipro             |
| Fosamax      | Valium                       | Penicillin   | Keflex            |
| Demerol      | Percodan                     | Erythromycin | Other Antibiotics |
| Tylenol      | Nitrous Oxide (laughing gas) | Clindamycin  | Latex Allergy     |
| Motrin/Advil | Phenergan                    | Tetracycline | Sulfa             |

ARE YOU ALLERGIC TO ANY OTHER MEDICATION? (Circle) Yes No If yes, please list \_\_\_\_\_

DO YOU SMOKE CIGARETTES? (Circle) Yes No If yes, how many packs per day \_\_\_\_\_

FOR WOMEN: Are you pregnant? (Circle) Yes No Are you taking birth control pills? (Circle) Yes No (Taking antibiotics may inactivate birth control pills)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please Circle)

- |                         |                     |                         |                               |
|-------------------------|---------------------|-------------------------|-------------------------------|
| Heart disease or attack | Stroke              | Epilepsy or seizures    | Fainting or dizzy spells      |
| Heart murmur            | Kidney trouble      | Cancer                  | Hepatitis                     |
| Irregular heartbeat     | Ulcers              | Arthritis               | Liver disease                 |
| Mitral valve prolapse   | High blood pressure | Glaucoma                | Blood transfusion             |
| Artificial heart valve  | Emphysema           | Pain in jaw joints      | Hemophilia                    |
| Heart pacemaker         | Tuberculosis (TB)   | Excessive bleeding      | Bruise easily                 |
| Heart surgery           | Asthma              | Anemia                  | Sexually transmitted diseases |
| Orthopedic implant      | Sinus trouble       | Alcoholism              | Fever blisters (herpes)       |
| Organ transplant        | Pollen allergies    | Substance abuse problem | AIDS or related               |
| Acid Reflux             | Diabetes            | Neurologic disorder     | HIV or related                |
| Osteoporosis            | Thyroid disease     | Psychiatric treatment   | Hearing disorder              |

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS? (Circle) Yes No If yes, please list \_\_\_\_\_

LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING \_\_\_\_\_

ARE YOU PRESENTLY TAKING OR HAVE YOU IN THE PAST TAKEN FOSAMAX, ACTONEL, BONIVA, ZOMETA OR A SIMILAR DRUG? (Circle) Yes No If so, you may be at risk for osteonecrosis of the jaw (ONJ).

APPOINTMENTS: Once an appointment is made, please remember this time has been reserved for you. Without 24-hour notification, you may incur a charge for failed or cancelled appointments.

PATIENT (OR GUARDIAN'S) SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_