Patient Information:

Mr. Ms. Mrs. Dr. First Name_____M.I._____Last Name_____

Street_____City_____State_____Zip_____

Sex: M F Birth Date_____Age_____SS#_____

Cell Phone(____)_____Home Phone (____)_____Work Phone (____)_____

Employer_____

Email_____Emergency Contact_____Tel(____)_____

Referring Dentist_____General Dentist_____

Physician Information:

Physician Name_____

Street_____City_____State_____Zip_____

Phone (_____)_____

Dental Insurance :

Primary Insurance Company _____Subscriber ID_____

Group #_____Group Name_____

Subscriber's Info: First Name_____ M.I._____Last Name_____

Birth Date_____Age_____SS#_____Relation to Patient_____

Street_____City_____State_____Zip_____

Pharmacy Information:

Name_____

Street_____City_____

Phone (_____)_____

Are you currently taking antibiotics for your dental problem? If yes, list the antibiotic and start date_____	YES	NO
Are you now or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, etc.)? If yes, list the medication and dose_____	YES	NO
Are you taking any blood thinners or anticoagulants (Coumadin, Warfarin, Aspirin, etc.)? If yes, list the drug and dosage_____	YES	NO
Have you ever been told by a physician or surgeon to take antibiotics prior to dental appointments due to conditions such as an artificial heart valve, heart transplant, joint replacement, history of rheumatic fever or other condition?	YES	NO
Do you have high blood pressure?	YES	NO
Do you have diabetes? If yes, what type? _____	YES	NO
Do you have Hepatitis? If yes, what type(s) and date of diagnosis_____	YES	NO
Do you have HIV or AIDS?	YES	NO
Are you allergic to latex?	YES	NO
Are you allergic to codeine?	YES	NO
Are you allergic to sulpha or sulpha containing drugs?	YES	NO
Are you taking any herbal medications (ex. St. John's wort)?	YES	NO

Are you allergic to any of the following antibiotics?

Penicillin (ex. Pen VK, Amoxicillin, Augmentin)	YES	NO
Clindamycin (Cleocin)	YES	NO
Metronidazole(Flagyl)	YES	NO
Azithromycin (Z- Pak)	YES	NO

Are you allergic to any of the following over the counter pain medications?

Ibuprofen (Advil)	YES	NO
Acetaminophen (Tylenol)	YES	NO
Naproxen (Aleve)	YES	NO
Aspirin	YES	NO

Do you have, or have you had any of the following?

Asthma	Yes	No	Bleeding Issues	Yes	No	Tuberculosis	Yes	No
Epilepsy/Convulsions	Yes	No	Medicated Depression	Yes	No	Cancer	Yes	No
Fibromyalgia	Yes	No	Lyme Disease	Yes	No	History of TMJ Pain	Yes	No
Trigeminal Neuralgia	Yes	No	Kidney Disease	Yes	No	History of Alcohol or Drug Addiction	Yes	No
Autoimmune Disease	Yes	No	Thyroid Issues	Yes	No	Heart Disease	Yes	No
Artificial Heart Valve or Heart Transplant	Yes	No	Joint Replacement (Hip, Knee, etc.)	Yes	No	Herpes	Yes	No
Angina	Yes	No	Radiation Therapy to Your Head and/or Neck	Yes	No	Low Blood Pressure	Yes	No
COPD	Yes	No	Sinus Issues	Yes	No	Bronchitis, Chronic Cough	Yes	No
Rheumatic Fever or Rheumatic Heart Disease	Yes	No						

Please circle your level of dental anxiety

Low	Medium	High

WOMEN ONLY: Do any of the following apply to you?

Pregnant	YES	NO
Breast Feeding	YES	NO
Taking Oral Contraceptives	YES	NO

Medications

Please list your medications below:

_____
_____
_____
_____
_____
_____
_____

I certify that the above information is correct

Signature_____Date_____