MEDICAL HISTORY

Patient Name

1. General Health:
   Excellent☐ Good☐ Fair☐ Poor☐
2. Physician's Name: _____
   Address: _____
3. Date of Last Physical: _____
4. Ever had a serious illness .....Yes☐ ....No☐
   If yes, explain: _____
5. Have you ever been told that you need to take an antibiotic prior to dental treatment? .....Yes☐ ....No☐
6. Are you pregnant .....Yes☐ ....No☐
   If so, how long? _____
7. Taking any medication? .....Yes☐ ....No☐
   If so, what? _____
   For what condition? _____
   Dosage _____

7A. Taking any herbal supplements? .....Yes☐ ....No☐
   If so, what? _____
   Dosage _____

Are you allergic to:

8. Penicillin .....Yes☐ ....No☐
9. Sulfa .....Yes☐ ....No☐
10. Tetracycline .....Yes☐ ....No☐
11. Codeine .....Yes☐ ....No☐
12. Darvon .....Yes☐ ....No☐
13. Amoxicillin .....Yes☐ ....No☐
14. Local Anesthetic .....Yes☐ ....No☐
    If so, what kind? _____
15. Aspirin .....Yes☐ ....No☐
16. Erythromycin .....Yes☐ ....No☐
16. Latex .....Yes☐ ....No☐
17. Any Other known allergies .....Yes☐ ....No☐

_____

18. Metals .....Yes☐ ....No☐
19. Any present dental concerns? .....Yes☐ ....No☐
20. Date of last dental cleaning? ..... _____

Do you now have or recently had:

(a) Gum Bleeding .....Yes☐ ....No☐
(b) Food Catching between teeth .....Yes☐ ....No☐
(c) Gum Pain .....Yes☐ ....No☐
(d) Gum Swelling .....Yes☐ ....No☐
(e) Sensitivity of Teeth .....Yes☐ ....No☐
(f) Soreness of Teeth .....Yes☐ ....No☐
(g) Bad Mouth Odor .....Yes☐ ....No☐
(h) Loose or Moving Teeth .....Yes☐ ....No☐
(i) Soreness in Jaw Muscles .....Yes☐ ....No☐
(j) Headaches .....Yes☐ ....No☐
(k) Noise in Jaw .....Yes☐ ....No☐

21. Are you seeing a dental specialist? .....Yes☐ ....No☐

Do you now have, or have you ever had any of the following? (Please check yes or no — if yes, when?)

22. Artificial Heart Valve .....Yes☐ ..No☐ _____
23. Rheumatic Fever .....Yes☐ ..No☐ _____
24. Heart Murmur .....Yes☐ ..No☐ _____
25. Bypass Surgery .....Yes☐ ..No☐ _____
26. Congenital Heart Defect .....Yes☐ ..No☐ _____
27. Bacterial Endocarditis .....Yes☐ ..No☐ _____
28. Mitral Valve Prolapse .....Yes☐ ..No☐ _____
29. Heart Attack .....Yes☐ ..No☐ _____
30. Angina .....Yes☐ ..No☐ _____
31. Stroke .....Yes☐ ..No☐ _____
32. Diabetes .....Yes☐ ..No☐ _____
33. Artificial Joint (hip, knee, etc.) Replacement .....Yes☐ ..No☐ _____
34. Emphysema .....Yes☐ ..No☐ _____
35. Tuberculosis .....Yes☐ ..No☐ _____
36. Bronchitis .....Yes☐ ..No☐ _____
37. Asthma .....Yes☐ ..No☐ _____
38. Hay Fever .....Yes☐ ..No☐ _____
39. Thyroid Trouble .....Yes☐ ..No☐ _____
40. Sinus Trouble .....Yes☐ ..No☐ _____
41. High or Low Blood Pressure ....Yes☐ ..No☐ _____
42. Seizures (Epilepsy) .....Yes☐ ..No☐ _____
43. Fainting Spells .....Yes☐ ..No☐ _____
44. Arthritis .....Yes☐ ..No☐ _____
45. Anemia .....Yes☐ ..No☐ _____
46. Prolonged Bleeding after extractions, cuts, surgery .....Yes☐ ..No☐ _____
47. Hepatitis .....Yes☐ ..No☐ _____
48. Liver Trouble .....Yes☐ ..No☐ _____
49. Ulcers .....Yes☐ ..No☐ _____
50. Aids .....Yes☐ ..No☐ _____
51. HIV Pos .....Yes☐ ..No☐ _____
52. Blood Transfusions .....Yes☐ ..No☐ _____
53. Lupus .....Yes☐ ..No☐ _____
54. Cancer/Chemo/Radiation .....Yes☐ ..No☐ _____
55. Tobacco .....Yes☐ ..No☐ _____
    If so, how often? _____
56. Alcohol use? .....Yes☐ ..No☐ _____
    If so, how often? _____
57. Xerostomia .....Yes☐ ..No☐ _____

CHECK DK IF YOU DON'T KNOW THE ANSWER TO THE FOLLOWING QUESTIONS.

58. Are you taking or scheduled to begin taking either of the medications, alendronate (Fosomax®) or risedronate (Actonel®) for osteoporosis or Paget's disease. . . .
    DK☐ ..Yes☐ ..No☐ _____
59. Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?. . . . . .
    DK☐ ..Yes☐ ..No☐ _____

_____ _____

Signature Date

Acct. # _____

Mr.

Mrs.

Miss _____ SS# _____ DOB: _____
(Last) (First) (Initial)

Address: _____
(Street) (Apt.#) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____
(Area code) (Area code) (ext)

E-Mail Address: _____ Cell Phone: _____

Full Time College Student?: .....Yes☐ ....No☐ Work Phone: _____
(Name of College)

Employer: _____ Address: _____

Spouses Name: _____ SS #: _____ DOB _____

Dependents: _____

Responsible Party: _____ SS#: _____

_____
Mailing Address If Different From Above

_____
Employer of Responsible Party Employers Address

DENTAL INSURANCE INFORMATION

1. Primary Insurance: _____ Policy #: _____

   Policy holder: _____ DOB: _____ SS#: _____

   Employer: _____ Address: _____

2. Secondary Insurance: _____ Policy #: _____

   Policy holder: _____ DOB: _____ SS#: _____

   Employer: _____ Address: _____

I understand that even though I may have some type of insurance coverage, I am responsible for payment of services. 1.5% per month will automatically be applied to account balance over 60 days (18% per year).

Signature: _____ Date: _____