

PATIENT INFORMATION

First Name	Last Name	Date of Birth	Gender
Mobile Phone #		Email	
Address			
Emergency Contact Name		Emergency Contact Phone #	

PREFERRED PHARMACY

Pharmacy Name	Pharmacy Phone
Address	

DENTAL HISTORY

How fearful are you of dental treatment (10 being the most)?			
Have you ever had gum surgery?	☐ Yes ☐ No	Have you ever had braces, or had your bite adjusted?	☐ Yes ☐ No
Do you have any dental implants in your mouth?	☐ Yes ☐ No	Have you ever had deep cleaning of your teeth?	☐ Yes ☐ No
		Date of last deep cleaning	

POLICY HOLDER

Insured First Name	Insured Last Name
Relation to Patient	Gender
Insured Social Security	Date of Birth

INSURANCE INFORMATION

Insurance Name	
Policy ID	Ins Phone Number
Group #	Group Name
Address	

☐ I certify I have read and I understand the questions. I acknowledge my questions have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her team, responsible for any errors or omissions that I have made in the completion of this form.

☐ I agree to receive SMS updates at the phone number provided above and understand that message frequency may vary. Msg & data rates may apply. Reply STOP to opt out.

☐ If I have dental insurance, my signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

☐ I hereby acknowledge a copy of the Notice of Privacy Practices has been made available to me (see form on website). I have been given the opportunity to ask any questions I may have regarding this Notice.

MEDICAL HISTORY

Patient Name: _____

Birth Date: _____

Are you in good health? ☐ Yes ☐ No Height _____ Weight _____ Are you under care of a physician? ☐ Yes ☐ NoAre you currently taking or planning to take antibiotics before dental treatment? ☐ Yes ☐ NoHave you been hospitalized in the past five years? ☐ Yes ☐ No Have you ever had general anesthesia? ☐ Yes ☐ NoHave you or your family had reactions to general anesthesia? ☐ Yes ☐ No Have you had the COMD vaccination? ☐ Yes ☐ NoAre you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Redast, Prolia, Xgeva, or Evista in the past 12 years? ☐ Yes ☐ No**WOMEN ONLY****1-4 below for women only:**

(Note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy?

☐ Yes ☐ No

2) Expected delivery date _____

3) Are you nursing?

☐ Yes ☐ No

4) Are you taking birth control pills?

☐ Yes ☐ No**ALLERGIES/REACTIONS**

YN	YN	YN	YN
☐ ☐ Penicillin	☐ ☐ Sulfa drugs	☐ ☐ Local anesthetic	☐ ☐ Amoxicillin
☐ ☐ Aspirin	☐ ☐ Codeine or other narcotics	☐ ☐ Latex	☐ ☐ Do you have any known allergies

Please list any allergies not listed above _____

MEDICAL CONDITIONS**Do you have, or have you had, any of the following diseases, medical conditions, or procedures?**

YN	YN	YN	YN
☐ ☐ AIDS / HIV	☐ ☐ Dementia	☐ ☐ High blood pressure	☐ ☐ Prosthetic implant
☐ ☐ Alzheimer's	☐ ☐ Diabetes	☐ ☐ High cholesterol	☐ ☐ History of Radiation
☐ ☐ Anemia	☐ ☐ Do you smoke or vape	☐ ☐ History of alcohol / drug abuse	☐ ☐ Respiratory problems
☐ ☐ Arthritis / Joint disease	Number of smoke/day _____	☐ ☐ History of marijuana / drug use	☐ ☐ Rheumatic fever
☐ ☐ Asthma	☐ ☐ Do you use chewing tobacco	☐ ☐ Infectious mononucleosis	☐ ☐ Sexually transmitted diseases
☐ ☐ Bleeding tendency	☐ ☐ Emphysema	☐ ☐ Irregular heart beat	☐ ☐ Sleep apnea / CPAP
☐ ☐ Blood transfusion	☐ ☐ Eye disease / Glaucoma	☐ ☐ Joint replacement	☐ ☐ Special diet
☐ ☐ Bronchitis	☐ ☐ Fainting spells	☐ ☐ Kidney trouble	☐ ☐ Stomach ulcers / acid reflux
☐ ☐ Bruise easily	☐ ☐ Hay fever / Sinus problems	☐ ☐ Liver disease	☐ ☐ Stroke
☐ ☐ Cancer	☐ ☐ Heart attack(s)	☐ ☐ Low blood pressure	☐ ☐ Thyroid trouble
☐ ☐ Chest pain / Angina	☐ ☐ Heart murmur	☐ ☐ Low blood sugar	☐ ☐ Trouble climbing 1-2 flights of stairs
☐ ☐ Chronic cough	☐ ☐ Heart pacemaker	☐ ☐ Mental health problems	☐ ☐ Tumor or growth
☐ ☐ Chronic fatigue / Night sweat	☐ ☐ Heart surgery	☐ ☐ Osteopenia	
☐ ☐ Convulsions / Epilepsy	☐ ☐ Heart trouble	☐ ☐ Osteoporosis	
☐ ☐ COVID-19	☐ ☐ Heart valve issues	☐ ☐ Pneumonia	
☐ ☐ Delay in healing	☐ ☐ Hepatitis	☐ ☐ Problems with immune system	

Any other medical conditions not listed above _____

MEDICATIONS**Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):**

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

PATIENT SIGNATURE

X

X

Signature of patient

Date

DOCTOR'S NOTES

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X

X

Signature of dentist

Date