List       FIRST       MI         If the patient is a minor, give name of parent or legal guardian:	Patient Information				
If the patient is a minor, give name of parent or legal guardian:	Patient Name:		N//	Date:	
Social Security #:					
Phone (HOME):	□ Male □ Female □ M	Married 🗆 Single 🗆 Child 🗆 Other _			
Address:	Social Security #:	Birth Date:	Weight	: Height:	
CITY       STATE       ZIP CODE         MEDICAL HISTORY         Date of last Dental Visit:       Name of Dentist:       Reason for Visit:         Whom may we thank for referring you to our practice?       Improvid Problems       OSTEOPROSIS medication? X         Mary you ever had any of the following? Please check those that apply:       Have you ever taken an         IV/AIDS       Epicpsy       Ilcres       Typoid Problems       OSTEOPROSIS medication? X         Mary ou ever had any of the following? Please check those that apply:       Have you ever taken an       Medicaten?       Medicaten?         Asprin Allergy       Glaacoma       Nervous Disorders       Started :       Medicaten?       Medicaten?         A Anemia       Gravits       Pacemaker       Stopped:       Medicaten?       Medicaten?         Astima       Heart Minur       Rheumatic Fever       Would you prefit to be sealated for surgical procede         Otdeine Allergy       High Blood Pressure       Stomach Problems       If yes, No         Diabetes?       Jandice       Stomach Problems       Prow       Are you appressure       Stomach Problems         Diabetes?       High Blood Pressure       Stomach Problems       Are you appressure       Yes No         Are you allergit to any medication? <td>Phone (HOME):</td> <td>(WORK):</td> <td></td> <td>(CELL):</td>	Phone (HOME):	(WORK):		(CELL):	
MEDICAL HISTORY         Reason for Visit:	Address:		EMAIL:		
MEDICAL HISTORY         Reason for Visit:		STATE		ZIP CODE	
Date of last Dental Visit:			IISTORY		
Whom may we thank for referring you to our practice?         Have you ever had any of the following? Please check those that apply:       Have you ever taken an         OK       Diplepsy       Ulcers       Thyroid Problems       OSTEOPOROSIS medication? X         Allergies       Excessive Bleeding       Mental Disorders       Tuberculosis       (EX: Fosamax/Actonel/Boniva/Aredia/Zon         Aspirin Allergy       Glaucoma       Nervous Disorders       Startet :	Date of last Dental Visit:			son for Visit:	
Have you ever had any of the following? Please check those that apply:       Have you ever taken an OSTENPONROSIS medication? OSTENPONROSIS medication? NOTENPONROSIS medication? NOTENPONROSIS medication? NOTENPONROSIS medication? NOTENPONROSIS medication? Note taken an an antipatrial value problems         Allergies       Excessive Bleeding       Mental Disorders       Tuberculosis       If X: Forsamac/Archael/Bonkya/Archael/Zom X: Construct/Archael/Bonkya/Archael/Bonk					
INTY AIDS       Epilepsy       Ulcers       Thyroid Problems       OSTEOPOROSIS medication? X         Allergies       Excessive Bleeding       Mental Disorders       Tuberculosis       (EX: Fosamac/Actanet/Baniva/Aredia/Zam         Aspirin Allergy       Glaucoma       Nervous Disorders       Startet :	-	•••			
□ Altergics       □ Excessive Bleeding       □ Mental Disorders       □ Tuberculosis       (EX: Fosumar/Actomel/Boniva/Aredia/Zom         □ Anapirin Altergy       □ Mitral Valve Prolapse       □ Tumors       □ Med taken?       □         □ Anemia       □ Growths       □ Pacemaker       Storped:       □         □ Antificial Joints       □ Head Injuries       □ Redication Treatment       Does dental treatment make you nervous?         □ Asthina       □ Heart Disease       □ Respiratory Problems       □ Slightly □ Moderately □ Extremely         □ Blood Disease       □ Heart Murmur       □ Rheumatic Fever       Would you prefer to be sedated for surgical procedu         □ Cancer       □ Hepatitis       □ Rheumatism       □ Yes □ No         □ Diabetes:Type       □ Jandice       □ Stomach Problems       □ Yes □ No         □ Diabetes:Type       □ Jandice       □ Stomach Problems       □ Yes □ No         □ Drug Addiction       □ Liver Disease       □ Taking Aspirin Daily       Are you taking birth control? □ Yes □ No         Have you ever had to pre-medications at this time? If yes, please list on Medication Information Form.         Have you ever had any complications following dental treatment? □ Yes □ No         If yes, please explain:				•	
□       Miral Valve Prolapse       Tumors       Met taken?         □       Anemia       Growths       □ Pacemaker       Started :         □       Anemia       Growths       □ Pacemaker       Stopped:         □       Artificial Joints       Hay Fever       □ Penicillin Allergy       □         □       Artificial Joints       Heat Ilyerse       □ Radiation Treatment       Does dental treatment make you nervous?         □       Astima       □       Heart Murrunr       Rheumatic Fever       Would you prefer to be sedated for surgical proceed         □       Cancer       □       Hepatitis       □       Rheumatism       □ Yes No         □       Dizziness       □       Jaundice       □       Stomach Problems       □ Yes No         □       Dizziness       □       Jaundice       □       Storack       For Women ONLY         □       Dizadetion       □       Lew Emits       □       Yes No         Are you altergic to any medication?       Haye you ever had an allergic reaction to a medication?       □ Yes No         □       Prova altergic to any medications following dental treatment?       □ Yes □ No       No         Haye you ever had to pre-medicate with antibiotics for dental treatment?       □ Yes □ No <t< td=""><td>1 1 2</td><td></td><td></td><td></td></t<>	1 1 2				
□ Aspirin Allergy       □ Glaucoma       □ Nervous Disorders       Started :			$\Box$ Tuberculosis (		
□       Anemia       □       Growths       □       Pacemaker       Stopped:         □       Artificial Joints       □       Hay Fever       □       Penicillin Allergy       □         □       Artificial Joints       □       Head Injurics       □       Radiation Treatment       Does dental treatment make you nervous?         □       Asthma       □       Heart Disease       □       Respiratory Problems       □       Slightly       □       Moderately       □       Extremely         □       Blood Disease       □       Heart Murmar       □       Rehumatic Fever       Would you prefer to be sedated for surgical proceed         □       Cadeer       □       Paditis       □       Rehumatic Fever       Would you prefer to be sedated for surgical proceed         □       Dizziness       □       Stonach Problems       □       □       Yes □ No         □       Dizziness       □       Stoke       For Women ONLY       No         □       Diver Disease       □       Taking Aspirin Daily       Are you atking birth control? □ Yes □ No         □       Broy addiction       Leukemia       □       Venereal Disease       Are you atking any medications at this time? If yes, please list on Medication Information Form. <tr< td=""><td></td><td></td><td></td><td>Med taken?</td></tr<>				Med taken?	
□       Arthritis       □       Hay Fever       □       Penicillin Allergy         □       Arthritis       □       Head Injuries       Radiation Treatment       Does dental treatment make you nervous?         □       Asthma       □       Heart Disease       □       Repiratory Problems       □       □       Stringer       □       Does dental treatment make you nervous?         □       Blood Disease       □       Heart Disease       □       Rheumatism       □       Yes □ No         □       Codeine Allergy       □       High Blood Pressure       □       Sins Problems       □       Yes □ No         □       Diabetes: Type       □       Jaundice       □       Stomach Problems       □       Yes □ No         □       Drug Addiction       □       Levter Disease       □       Stomach Problems       □       Yes □ No         □       Drug Addiction       □       Levter Disease       □       Stomach Problems       □       Yes □ No         □       Proy addiction       □       Lever Disease       □       Stomach Problems       □       Yes □ No         □       Proy addiction       □       Proy ou taking gany medications at this time? If yes, please ton Medication Information Form. <td></td> <td></td> <td></td> <td>Started :</td>				Started :	
□       Artificial Joints       □       Head Injuries       □       Radiation Treatment       □       Does dental treatment make you nervous?         □       Asthma       □       □       Blood Disease       □       Reepiratory Problems       □       Slightly       □       Moderately       □       Externely         □       Blood Disease       □       Heart Murmur       □       Rheumatis       □       Yes       No         □       Diabetes:Type       □       Jandice       □       Sinus Problems       □       Yes       No         □       Diabetes:Type       □       Jandice       □       Stroke       For Women ONLY         □       Dizziness       □       Kidney Disease       □       Stroke       For Women ONLY         □       Drug Addiction       □       □       Previou allergic to any medication?       Have you ever had an allergic reaction to a medication?         If yes, describe:	$\Box$ Anemia $\Box$ Growths	□ Pacemaker		Stopped:	
□       Asthma       □       Heart Disease       □       Respiratory Problems       □       Slightly       □       Moderately       □       Extremely         □       Blood Disease       □       Heart Murmur       □       Rheumatism       □       Yes       No         □       Codeine Allergy       □       High Blood Pressure       □       Sinus Problems       □       Yes       No         □       Dizziness       □       Kidney Disease       □       Stroke       For Women ONLY         □       Drag Addiction       Liver Disease       □       Taking Aspirin Daily       Are you taking birth control?       Yes<	$\Box$ Arthritis $\Box$ Hay Few	ver			
□       Blood Disease       □       Heart Murmur       □       Rheumatic Fever       Would you prefer to be sedated for surgical procedu         □       Caccer       □       □       Rheumatism       □       Yes □ No         □       Cacdeine Allergy       □       Jaundice       □       Stomach Problems       □       Yes □ No         □       Diabetes:Type       □       Jaundice       □       Stomach Problems       □       □       Yes □ No         □       Diabetes:Type       □       Jaundice       □       Stomach Problems       □       □       Yes □ No         □       Diabetes:Type       □       Jaundice       □       Stomach Problems       □       □       No       □       If yes, lease ist on Medication Information Form.         Have you ever had to pre-medicate with antibiotics for dental treatments?       □       Yes □       No       If yes, please explain:	□ Artificial Joints □ Head In	juries 🛛 Radiation Treatmen	nt I	Does dental treatment make you nervous?	
□       Cancer       □       Hepatitis       □       Rheumatism       □       Yes □ No         □       Oddeine Allergy       □       High Blood Pressure       □Sinus Problems	□ Asthma □ Heart D	isease	ems	□ Slightly □ Moderately □ Extremely	
□ Cancer       □ Hepatitis       □ Rheumatism       □ Yes □ No         □ Oddine Allergy       □ High Blood Pressure       □ Sinus Problems       □         □ Dizziness       □ Kidney Disease       □ Stronke       For Women ONLY         □ Drzy Addiction       □ Liver Disease       □ Taking Aspirin Daily       Are you taking birth control?       □ Yes □ No         □ Brup Addiction       □ Liver Disease       □ Taking Aspirin Daily       Are you taking birth control?       □ Yes □ No         □ Arer you allergic to any medication? Have you ever had an allergic reaction to a medication?       If yes, describe:	□ Blood Disease □ Heart M			ou prefer to be sedated for surgical procedur	
□ Codeine Allergy       High Blood Pressure       Sinus Problems         □ Diaziness       □ Stomach Problems         □ Dizziness       □ Kidney Disease       □ Stomach Problems         □ Dizziness       □ Kidney Disease       □ Taking Aspirin Daily       Are you taking birth control?       □ Yes □ No         □ Emphysema       □ Leukemia       □ Venereal Disease       Are you pregnant?       □ Yes □ No         Are you allergic to any medication? Have you ever had an allergic reaction to a medication?       If yes, describe:	□ Cancer □ Hepatitis	s 🗆 Rheumatism		· · · ·	
□ Diabetes:Type					
□ Dizziness       □ Kidney Discase       □ Stroke       For Women ONLY         □ Drug Addiction       □ Liver Discase       □ Taking Aspirin Daily       Are you taking birth control? □ Yes □ No         □ Brug Addiction       □ Liver Discase       □ Taking Aspirin Daily       Are you pregnant? □ Yes □ No         □ Are you allergic to any medication?       Have you ever had an allergic reaction to a medication?       If yes, describe:					
□ Drug Addiction       □ Liver Disease       □ Taking Aspirin Daily       Are you taking birth control? □ Yes □ No         □ Brmphysema       □ Leukemia       □ Venereal Disease       Are you pregnant? □ Yes □ No         Are you allergic to any medication? Have you ever had an allergic reaction to a medication?       If yes, describe:         Are you taking any medications at this time? If yes, please list on Medication Information Form.         Have you ever had any complications following dental treatments?       □ Yes □ No         If yes, please explain:				For Women ONI V	
□ Emphysema □ Leukemia □ Venereal Disease <u>Are you pregnant? □ Yes □ No</u> Are you allergic to any medication? Have you ever had an allergic reaction to a medication? If yes, describe:	Drug Addiction	isaasa $\Box$ Taking Aspirin D	oily A.		
Are you allergic to any medication? Have you ever had an allergic reaction to a medication?       If yes, describe:	Emphyseme I subem		any A		
If yes, describe:			11		
Are you taking any medications at this time? If yes, please list on Medication Information Form.   Have you ever had to pre-medicate with antibiotics for dental treatments?   Yes   No   Have you ever had any complications following dental treatment?   Yes   No    If yes, please explain:					
Have you ever had to pre-medicate with antibiotics for dental treatments? □ Yes □ No         Have you ever had any complications following dental treatment? □ Yes □ No         If yes, please explain:					
Have you ever had any complications following dental treatment? □ Yes □ No         If yes, please explain:					
If yes, please explain:					
Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No If yes, please explain:Are you now under the care of a physician? □ Yes □ No If yes, please explain:					
Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No If yes, please explain:Are you now under the care of a physician? □ Yes □ No If yes, please explain:	If yes, please explain:				
Name of Physician:       Phone #:         Do you have any health problems that need further clarification?       Yes         No       If yes, please explain:         Do you use tobacco?       Yes         Photographs are sometimes gained from patients' treatment that may be used in clinical presentations; continuing education as well as case review within our office and/or with the patient's referring dentist/doctor.         If you prefer photographs not be taken, please check box.       No photographs         To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail.         Signature of patient, parent or guardian:	Have you been admitted to a hospital or needed emergency care during the past two years? $\Box$ Yes $\Box$ No				
Name of Physician:       Phone #:	Are you now under the care of a physician? $\Box$ Ves $\Box$ No If yes please explain:				
Name of Physician: Phone #: Do you have any health problems that need further clarification? □ Yes □ No If yes, please explain: <b>Do you use tobacco?</b> □ <b>Yes</b> □ <b>No If yes, What and How often?</b> <b>Photographs</b> are sometimes gained from patients' treatment that may be used in clinical presentations; continuing education as well as case review within our office and/or with the patient's referring dentist/doctor. If you prefer photographs not be taken, please check box. □ No photographs To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail. Signature of patient, parent or guardian:Date:					
Do you have any health problems that need further clarification?  Yes No If yes, please explain: Do you use tobacco?  Yes No If yes, What and How often? Photographs are sometimes gained from patients' treatment that may be used in clinical presentations; continuing education as well as case review within our office and/or with the patient's referring dentist/doctor. If you prefer photographs not be taken, please check box.  No photographs To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail. Signature of patient, parent or guardian:Date:	Name of Physician: Phone #:				
Do you use tobacco? □ Yes □ No If yes, What and How often? Photographs are sometimes gained from patients' treatment that may be used in clinical presentations; continuing education as well as case review within our office and/or with the patient's referring dentist/doctor. If you prefer photographs not be taken, please check box. □ No photographs To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail. Signature of patient, parent or guardian:Date:	Do you have any health pro	blems that need further clarific	cation? $\Box$ Yes $\Box$ No		
Photographs are sometimes gained from patients' treatment that may be used in clinical presentations; continuing education as well as case review within our office and/or with the patient's referring dentist/doctor. If you prefer photographs not be taken, please check box. □ No photographs To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail. Signature of patient, parent or guardian:	If yes, please explain:				
education as well as case review within our office and/or with the patient's referring dentist/doctor. If you prefer photographs not be taken, please check box. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail. Signature of patient, parent or guardian:Date:	Do you use tobacco?  Ves	s 🗆 No If yes, What and How	v often?		
If you prefer photographs not be taken, please check box.   No photographs  To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail.  Signature of patient, parent or guardian:		0 1	2	1 2	
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail. Signature of patient, parent or guardian:Date:					
I ever have any change in my health; I will inform the doctors at the next appointment without fail. Signature of patient, parent or guardian:Date:					
	I ever have any change in my health; I will inform the doctors at the next appointment without fail.				
Previous Surgeries.	Signature of patient, parent or	guardian:		Date:	
	Previous Surgeries:				