Name: _____ SSN: _____
Address: _____ City: _____ Zip: _____
Birthdate: _____ hm ph:_____ wk ph: _____ cell ph: _____

Name of parent or guardian if under 18 years old _____
address and ph.# if different
_____

email address: _____

Do we have permission to leave messages for you at home? Yes No at work? Yes No

In case of emergency contact: _____ ph # _____
Physician's name: _____
address: _____

List **all** medications (including aspirin) you are currently taking and state the reasons for taking them. **This includes supplements and herbal remedies.**
_____
_____
_____

Are you or have you ***ever*** taken the following medications for osteoporosis or bone cancer? Actonel (risedronate), Boniva (ibandronate), Didronel (etidronate), Fosamax (aledronate), Fosamax Plus D (aledronate), Skelid (tiludronate), Aredia (pamidronate), Bonefos (clodronate), Zometa (zolendronic acid) YES NO

Are you allergic to ***any*** medication or antibiotic? If so, please list and describe the reaction.
_____

Do you have a contract with your medical doctor regarding pain medication? yes no

Have you ever had any problems with any local anesthestics (such as novocaine or lidocaine)?
_____

Do you have or have you had any of these illnesses in the past? Please indicate by circling Y or N.

Y N High blood pressure. If so, is it controlled? Y N Medication? If so, list _____
Y N Heart murmur. If so, were you told to take antibiotics before dental treatment? Y N
Y N Mitral valve prolapse
Y N Heart trouble. If so, what type? _____
Y N Rheumatic heart fever
Y N Joint replacement. If so, which joint and when? _____
Y N Liver trouble. If so, what kind? _____
Y N Had prolonged bleeding after surgery?
Y N Diabetes. If so, what type_____ Is it controlled? Y N
Y N Hepatitis. If so, what type? _____ Is it active? _____
Y N Tuberculosis. If so, is it active? Y N
Y N TMJ (jaw joint) problems. If so, what kind? _____

Date: _____ initial of patient or parent/guardian: _____

Updated: date: _____ initial: _____ date: _____ initial: _____

date: _____ initial: _____ date: _____ initial: _____

date: _____ initial: _____ date: _____ initial: _____

Y N Stroke
Y N Allergic to latex or rubber products?
Y N Does your jaw click or pop?
Y N Cancer of the head or neck.. If so, did you receive radiation treatments? Y N
Y N Bleeding disorders. If so, what type? _____
Y N Epilepsy or seizures? Y N
Y N Are you pregnant? If so, how far along? _____
Y N Seasonal allergies
Y N Kidney trouble. If so, what kind? _____
Y N Neurological problems
Y N Ulcer or colitis
Y N Blood disorders. If so, what type? _____
Y N Psychiatric care / emotional problems
Y N Gum problems. If so, what kind? _____
Y N Dry mouth
Y N Glaucoma
Y N Asthma
Y N Venereal disease
Y N Sinus problems. If so, what kind? _____
Y N Arthritis
Y N HIV positive
Y N Anemia
Y N Low blood pressure
Y N Persistant cough

Describe ***any*** current medical treatment even though not listed above.

_____
_____
_____
_____
_____

List ***any*** other diseases you have or surgeries you have had.

_____
_____
_____
_____
_____

When were your last dental x-rays taken? _____

Prior dentist's name and city _____

*** I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. It is understood that ENGLISH is the language that I understand and use to communicate.**

Signature (patient or parent/guardian) _____ date _____

Updated:

date: _____ initial: _____ date: _____ initial: _____

date: _____ initial: _____ date: _____ initial: _____

date: _____ initial: _____ date: _____ initial: _____