

COMPLETE THIS QUESTIONNAIRE AS ACCURATELY AS POSSIBLE!

Patient Name _____ Preferred name _____
 _____ First _____ Last _____
 Address _____
 _____ Street _____ City _____ State _____ Zip _____
 Date of birth ____/____/____ Marital Status _____ Home# _____ Work# _____ Mobile# _____
 E-Mail _____ Preferred method of communication? Text ☐ Email ☐ Phone ☐
Emergency contact other than spouse: Name _____ Relationship to patient _____ Phone _____

DENTAL INSURANCE(Please provide the office with your dental insurance card)

Dental Insurance Co _____ Phone# _____ Insured Name _____ Insured DOB _____
 Insured ID# _____ Insured SSN# _____ (for insurance purposes) Group# _____
 Relationship to patient _____ Name of person responsible for account _____

HEALTH HISTORY**LIST ALL MEDICATIONS AND FOR WHAT REASON:**

 Physician name and phone#: _____

 Pharmacy name and phone#: _____

Do you have, or ever had an allergic reaction to:

Local Anesthetics.....Yes ☐ No ☐
 Penicillin.....Yes ☐ No ☐
 Sulfa Drugs.....Yes ☐ No ☐
 Aspirin.....Yes ☐ No ☐
 Codeine.....Yes ☐ No ☐
 Latex.....Yes ☐ No ☐
 Bandaid Only.....Yes ☐ No ☐
 Other allergies: _____
 Number of alcoholic drinks per week: _____
 Do you suffer from Dry-Mouth?.....Yes ☐ No ☐
 Mild ☐ Moderate ☐ Severe ☐

History of heart issues?.....Yes ☐ No ☐
 Endocarditis.....Yes ☐ No ☐
 Artificial heart valve.....Yes ☐ No ☐
 Heart Valve Repair.....Yes ☐ No ☐
 Valvulitis.....Yes ☐ No ☐
 Congenital Heart Conditions.....Yes ☐ No ☐
 Unrepaired Cyanotic CHD.....Yes ☐ No ☐
 Heart/Organ Transplants.....Yes ☐ No ☐
 Palliative Shunts & Conduits.....Yes ☐ No ☐
 Stroke.....Yes ☐ No ☐
 Other: _____

Abnormal blood pressure.....Yes ☐ No ☐ If yes.....High ☐ Low ☐
 Excessive bleeding.....Yes ☐ No ☐
 Anemia.....Yes ☐ No ☐

Blood thinners?.....Yes ☐ No ☐
 If yes, name? _____

Check if taken daily: Fish Oil ☐ Aspirin ☐ Ibuprofen ☐

In the last 6 months, have you taken one of these
 Bisphosphonates or derivatives for the prevention of
 Osteoporosis? Yes ☐ No ☐
 If yes, name? Fosamax ☐ Actonel ☐ Didronel ☐ Boniva ☐
 Aredia ☐ Skelid ☐ Zometa ☐ Prolia ☐ Reclast ☐ Other: _____

Take antibiotics prior to dental treatment?.....Yes ☐ No ☐
 If yes, reason: _____
 Joint replacement(s)? Yes ☐ No ☐
 If yes, which one? _____
 Date of the surgery? _____
 Name of surgeon? _____

Auto-immune disease: Name? _____ Yes ☐ No ☐
 Neuropathy.....Yes ☐ No ☐
 Diabetes Type? _____ Yes ☐ No ☐
 Hepatitis.....Yes ☐ No ☐
 Liver disease.....Yes ☐ No ☐
 Renal disease.....Yes ☐ No ☐
 HIV.....Yes ☐ No ☐
 Cancer.....Yes ☐ No ☐
 Radiation Treatment When? _____ Yes ☐ No ☐
 Chemotherapy When? _____ Yes ☐ No ☐
 Asthma.....Yes ☐ No ☐
 Tuberculosis.....Yes ☐ No ☐
 COPD.....Yes ☐ No ☐
 GERD (Acid Reflux).....Yes ☐ No ☐
 Tobacco.....Yes ☐ No ☐
 Vape/E-cigarette.....Yes ☐ No ☐
 Dip.....Yes ☐ No ☐

For women:

Are you pregnant?.....Yes ☐ No ☐
 Check if you are taking any:.....Hormones ☐ Birth control ☐

Please describe other health issues not listed:

Signature

Date