PATIENT INFORMATION

Name: _____ Birthdate: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Residence: _____ Business: _____

Cell: _____ Email: _____

Employed By: _____ Occupation: _____ How Long: _____

Husband or Wife's Name: _____ Employed By: _____

Whom may we thank for referring you to our office: _____

Name of your general dentist: _____

IN AN EMERGENCY, CONTACT

Name: _____ Phone #: _____

MEDICAL HISTORY

Are you under a physician's care? _____ Phone #: _____

Have you ever been hospitalized or had a major operation? _____

Have you ever had a serious injury to your head or neck? _____

Are you taking any medications, pills or drugs? _____ What? _____

Do you smoke cigarettes? _____ Are you allergic to any medications or substances? Please check box below.

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Latex Rubber ❑ Other: _____

WOMEN (PLEASE CHECK) ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Oral contraceptives

IF YES TO ANY OF THE STARRED QUESTIONS, PREMEDICATION MAY BE REQUIRED

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble	❑	❑	Low Blood Pressure	❑	❑	Radiation Treatments	❑	❑	Hepatitis B (Serum)	❑	❑
Irregular Heart Beat	❑	❑	Blood Disease	❑	❑	Chemotherapy	❑	❑	Kidney Problems	❑	❑
Angina/Chest Pain	❑	❑	Excessive Bleeding	❑	❑	Diabetes	❑	❑	Renal Dialysis	❑	❑
Heart Attack/Failure	❑	❑	Hemophilia	❑	❑	Excessive Thirst	❑	❑	Thyroid Disease	❑	❑
Congenital Heart Disorder	❑	❑	Leukemia	❑	❑	Hypoglycemia	❑	❑	Arthritis/Gout	❑	❑
Artificial Heart Valve	❑	❑	Recent Transfusion	❑	❑	Liver Disease	❑	❑	Cortisone Medication	❑	❑
Heart Surgery**	❑	❑	Lung Disease	❑	❑	Epilepsy/Seizures	❑	❑	AIDS	❑	❑
Stroke	❑	❑	Tuberculosis	❑	❑	Fainting/Dizziness	❑	❑	HIV Positive	❑	❑
High Blood Pressure	❑	❑	Cancer	❑	❑	Hepatitis A (Infections)	❑	❑	Drug Addiction	❑	❑

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... ❑ Yes ❑ No

Date: _____ If Yes, have you had any complications? _____

Artificial (prosthetic heart valve..... ❑ Yes ❑ No

Previous infective endocarditis ..... ❑ Yes ❑ No

Damaged valves in transplanted heart ..... ❑ Yes ❑ No

Congenital heart disease (CHD)..... ❑ Yes ❑ No

Unrepaired, cyanotic CHD..... ❑ Yes ❑ No

Repaired CHD with residual defects..... ❑ Yes ❑ No

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? ❑ Yes ❑ No

Date Treatment began: _____