MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

	Yes	No
1. **ARE YOU REQUIRED TO TAKE PREMEDS PRIOR TO DENTAL TREATMENT?**	☐	☐
2. Has there been any change in your general health within the past year?	☐	☐
Please specify______		
3. Are you under the care of a physician for a current problem?	☐	☐
Reason______		
4. Have you been hospitalized within the past five years?	☐	☐
Reason______		
5. Are you taking any medications or drugs?	☐	☐
Please specify______		
6. Have you received therapy for alcoholism or drug addiction during the past five years?	☐	☐
7. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics, latex, sulfite, or other medications? Please Specify ______	☐	☐
8. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?	☐	☐
9. Have you ever required a blood transfusion?	☐	☐
Please explain______		
10. Have you ever had surgery and/or radiation for a tumor, growth or other condition?	☐	☐
11. Have you ever been tested for HIV infection (AIDS)?	☐	☐

result of test: Date______ ☐ Positive ☐ Negative

12. Date of last physical exam______

13. Do you have or have you had any of the following (please check):

- ☐ High Blood Pressure
- ☐ Heart Murmur or prolapsed valve (MVP)
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Cardiovascular disease: heart attack, stroke, by-pass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g., anemia)
- ☐ Venereal disease
- ☐ Asthma
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Sinus Trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Kidney problems
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer

	Yes	No
14. Do you have any disease, condition, or problem not listed above?	☐	☐
Please specify______		

Women:

	Yes	No
15. Are you pregnant?	☐	☐
16. Are you nursing?	☐	☐
17. Do you take birth control pills?	☐	☐

If YES, please be advised that if you take antibiotics, an alternate method of birth control must be used.

18. Do you take:

☐ Fosomax (Alendronate)	☐ Evista (Raloxifene)	☐ Clondronate (Bonefos, Loron)	☐ Olpadronate
☐ Boniva (Ibandronate)	☐ Aredia (Pamidronate APD)	☐ Tilundronate (Skelid)	☐ Zoledronate (Zometa, Aclasta)
☐ Actonel (Risedronate)	☐ Etidronate (Didronel)	☐ Neridronate	☐ Reclast
☐ **Denosumab (Xgeva)**			

	Yes	No
19. Have you been given an IV Bisphosphonate?	☐	☐

All of the above information is true to the best of my knowledge.

Date______ Signature of Patient*______

*All signatures must be by parent or guardian if patient is under the age of 18.

Date:

Patient Information

Name____ Soc. Sec. #______________
Last Name First Name Initial

Address______________________________ Home Ph.______________ Cell______________

City____ State ________ Zip______________

Sex ☐ M ☐ F Age_____ Birthdate____________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner

Patient Employed by______________________________________ Occupation______________

Bus. Ph.______________________ Email Address______________________________________

General Dentist____

Whom may we thank for referring you? ☐ General Dentist. ☐ Ins. Comp. ☐ Other______________

In case of emergency who should be notified?__________________________ Phone______________

Primary Insurance

Person Responsible for Account____
Last Name First Name Initial

Relationship to Patient__________________________ Birthdate__________ Soc. Sec. #______________

Address (if different from patient's)____________________________________ Home Ph.______________

City____ State ________ Zip______________

Person Responsible Employed by__________________________________ Bus. Ph.______________

Insurance Company____

Contract#__________________ Group #__________________ Subscriber #______________________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name__________________________ Relation to Patient__________ Birthdate______________

Address (if different from patient's)______________________________________ Phone______________

City__________________________________ State ______ Zip________ Bus. Ph.______________

Insurance Company______________________________________ Soc. Sec. #______________

Contract#__________________ Group #__________________ Subscriber #______________________

Method of Payment

Which of the following methods of payment will you be using? (Estimated co-pay must be paid at time of service.)

Method of Payment: ☐ Cash ☐ Check ☐ VISA ☐ MC ☐ Care Credit

All information written is true and complete. **SIGNATURE:**______________________________ **DATE:**______________

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. **INITIALS**______________

Updates (date & initial)______________ ______________ ______________ ______________ ______________