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Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ (Last) ____________ (First) ____ (MI) ____________ (Preferred Name)

Title: ________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ________ **Prev. Visit:** ________ **Email Address:** ____________

Phone: ________ (Home) ________ (Mobile) ________ (Work) ____ (Ext) **Best time to call:** ____________

Address: ____________ (Address 1) ____________ (Address 2)

____________ (City) ____ (State) _____-____ (Zip Code)

DO YOU HAVE or HAVE YOU EVER HAD:

☐ Allergies	☐ Amoxocillin	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Aspirin Allergy	☐ Asthma	☐ Blood Disease
☐ Breathing/Sleep Prob	☐ Cancer	☐ Chemotherapy	☐ Codeine Allergy
☐ Cortisone Meds	☐ Currently Pregnant	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Frequent Headaches
☐ Glaucoma	☐ Growths	☐ Hay Fever	☐ Head Injuries
☐ Headaches/TMJ issues	☐ Heart Murmur	☐ Heart Problems	☐ Heart Valve Replacem
☐ Hepatitis	☐ High Blood Pressure	☐ High/Low Cholesterol	☐ HIV
☐ Hormone Deficiency	☐ Jaundice	☐ Kidney Disease	☐ Latex Allergy
☐ Liver Disease	☐ Local Anesthesia	☐ Lumps in the mouth	☐ Mental Disorders
☐ Metals Allergy	☐ Nervous Disorders	☐ Neurologic Problems	☐ Osteoporosis
☐ Other	☐ Pacemaker	☐ Penicillin Allergy	☐ premed
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Stomach Problems	☐ Street drugs	☐ Stroke
☐ Sulfa Allergy	☐ Taking Supplements	☐ Tetracycline Allergy	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease
☐ Vicodin Allergy			

1. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ◯ Yes ◯ No

2. Hospitalization for illness or injury ◯ Yes ◯ No

3. Contact lenses ◯ Yes ◯ No

4. Viral infections and cold sores ◯ Yes ◯ No

5. Hives, skin rash, hay fever ◯ Yes ◯ No

6. Do you have a cough? * ◯ Yes ◯ No

7. Do you have or have you felt hot or feverish recently (14-21) days? * ◯ Yes ◯ No

8. Have you experienced recent loss of taste or smell? * ◯ Yes ◯ No

9. Are you in contact with any confirmed COVID-19 positive patients? * ◯ Yes ◯ No

ARE YOU:

Presentlly being treated for any other illnesses ◯ Yes ◯ No

Aware of a change in your health (i.e. fever, new cough) ◯ Yes ◯ No

Taking medication for weight management (i.e. fen-phen) ◯ Yes ◯ No

Often exhausted or fatigued ◯ Yes ◯ No

A smoker, smoked previously, or use smokeless tobacco ◯ Yes ◯ No

Often unhappy or depressed ◯ Yes ◯ No

FEMALE - taking birth control pills ◯ Yes ◯ No

FEMALE - Currently pregnant ◯ Yes ◯ No

MALE - prostate disorders ◯ Yes ◯ No

Have you ever had any illness not listed above ◯ Yes ◯ No

Describe any current medical treatment, impending surgery genetic/developmental delay, or other treatment that may possibly effect your dental treatment. (i.e. Botox, Collagen injections)

____

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____

Do you have any health problems that need further clarifications? ◯ Yes ◯ No

If yes, please explain:

____

____

List all medications, supplements, and or actions taken within the last two years

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PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Are there changes? * ◯ Yes ◯ No

Response Date: ____________