The following confidential information (PHI) is for our records. Our office complies with HIPPA guidelines.

_____ Age: _____
(Dr., Mr., Mrs., Ms., Other) first name middle initial last name

Home Address_____ Phone (___)_____
street
_____ Cell (___)_____
city state zip code

Email Address _____ **Preferred contact method:** Text Email Call

Date of Birth _____ ID/Driver's License/Passport_____ Soc. Sec. No. _____

Patient Employed by_____ Occupation_____

Business Address_____ Phone (___)_____

Spouse and/or Emergency Contact _____ Phone (___)_____

Parent/Guardian Information _____ Phone (___)_____

Name of Dental Insurance Company _____ Sex F M N/A

Insured Name _____ DOB _____ ID#_____

Please feel free to discuss treatment cost prior to treatment being rendered. Either the front desk staff or the treating doctor will be happy to discuss any aspects of your treatment.

Name of family Physician _____ Phone (___)_____

Name of your Dentist _____ Phone (___)_____

Referred by _____

Other Dental Specialist you have consulted, if any _____

HEALTH HISTORY

Please answer each of the following questions

Are you in good health?_____ Yes No

Are you being treated by a physician for any reason?_____ Yes No

If yes, explain_____

Are you allergic to or have you had an adverse reaction to any drugs or medication?_____ Yes No

If yes, explain_____

Are you allergic to latex?_____ Yes No

Are you subject to abnormal bleeding or bruising?_____ Yes No

Have you had or been treated for nervous disorders, fainting, dizziness, numbness, weakness or seizures?

If yes, circle which_____ Yes No

Have you had or been treated for Hepatitis, STI, HIV, AIDS, HPV, Tuberculosis, or Rheumatic Fever?

If yes, circle which_____ Yes No

Have you had or been treated for heart trouble, chest pain, high blood pressure, breathing difficulty or asthma?

If yes, circle which_____ Yes No

Have you had or been treated for liver disorders, kidney problems, ulcers, intestinal problems or diabetes?

If yes, circle which_____ Yes No

Do you have a heart murmur, mitral valve prolapse, pacemaker, artificial heart valve or joint, or other implanted prothesis? Are you required to pre-medicate?_____ Yes No

If yes, circle which_____ Yes No

Have you ever taken bisphosphonate medication? e.g. Fosamax, Zometa, Actonel or Boniva_____ Yes No

Have you ever taken RANKL inhibitors? e.g. Denosumab (Xgeva or Prolia)_____ Yes No

Are you taking any medications at present?_____ Yes No

Name of medication?_____

What condition is being treated?_____

Have you had an unfavorable reaction from previous dental treatment or dental anesthetic?_____ Yes No

Do you have difficulty opening or keeping your mouth open?_____ Yes No

Do you have a history of TMJ problems or jaw pain?_____ Yes No

Female Patients: Months Pregnant _____ Obstetricion _____
name phone

Date _____ Signature _____

*Parent Signature if Patient Under Age 18