Name: ____________________ **DOB:** ___/___/___ **Today's Date**: ______________

Social Security#:____________________ **DL#**______________**Email:** ______________________________

Home Address: ______________________________**City:**______________________**Zip:**__________

Cell (____) ____________________ **Home (____)** __________________ **Wk (____)**________________

Referred By: ______________**Primary Physician?**______________________**Office Ph:**______________

NPI________________________

Are you allergic to:

Y N Aspirin	Y N Erythromycin	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Jewelry/ Metals	Y N Sulfa Drugs	Y N Penicillin
Y N Codeine	Y N Latex	Y N Dental Anesthetics	Y N Other

Please list other drugs / materials that cause allergic reactions:

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Are you taking any of the following? (specify name of medication)

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes	Y N Thyroid Med.
Y N Antibiotics	Y N Blood Press Med.	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	
Y N Aspirin	Y N Digitalis/ Heart	Y N Steroids/Cortisone	

Are you taking any prescription/ over-the-counter-drugs not listed above? N Y (please list):

For Women: Are you taking birth control pills? Y N Are you pregnant? Unsure N Y Wk#_____
Are you nursing? Y N

Do you or have you experienced the following:

Y N Abnormal Bleeding	Y N Difficulty Swallowing	Y N Heart Attack	Y N Psychiatric Problems
Y N Alcohol Abuse	Y N Dizziness	Y N Heart Murmur	Y N Radiation Treatment
Y N Anemia	Y N Drug Abuse	Y N Heart Surgery	Y N Rheumatic Fever
Y N Arthritis	Y N Dry Mouth	Y N Hemophilia	Y N Ringing in Ears
Y N Artificial Bones/Joints	Y N Emphysema	Y N Hepatitis A B or C (**circle**)	Y N Scarlet Fever
Y N Artificial Valves	Y N Epilepsy	Y N Herpes	Y N Seizures
Y N Asthma	Y N Excessive Thirst	Y N High Blood Pressure	Y N Shingles
Y N Blood Transfusion	Y N Fainting Spells	Y N HIV+/ AIDS	Y N Sickle Cell Disease
Y N Cancer	Y N Bisphosphonate (Fosamax)	Y N Hospitalized for any Reason	Y N Sinus Problems
Y N Chemotherapy	Y N Fever Blisters	Y N Kidney Problems	Y N Steroid Therapy
Y N Chest Pain	Y N Frequent Urination	Y N Liver Disease	Y N Stroke
Y N Colitis	Y N Glaucoma	Y N Low Blood Pressure	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N Hay Fever	Y N Lupus	Y N Tonsillitis
Y N Diabetes	Y N Headaches	Y N Mitral Valve Prolapse	Y N Tuberculosis (TB)
Y N Difficulty Breathing	Y N Pacemaker	Y N Persistent Cough	Y N Venereal Disease

Y N Family history of: (**circle**) Diabetes / Heart Problems / Tumors

Please list any serious medical condition(s) you have experienced: ______________________________________

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Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need, including but not limited to x-rays, examinations, and diagnostics tests. I have provided an opportunity to review the Notice of Privacy Practices. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature______________________________ Date__________ Doctor Signature:________________