

Date _____

Personal Information

Last Name _____ First _____ Middle _____

Home Address _____ City _____

State _____ Zip _____ Social Security No. _____

Home Ph. _____ Work Ph. _____ Cell Ph. _____

Date of Birth ____/____/____ Marital Status: Married ____ Single ____ Widow ____

Employer _____ Occupation _____

Business Address _____ Bus. Ph. _____

Spouse Name _____

Employer _____

Business Address _____ Bus. Ph. _____

Dentist Name _____ Phone _____

Dentist Address _____

City _____ State _____

Guarantor Information

Name _____ Relationship _____

Home Address _____ City _____

State _____ Zip _____ Social Security No. _____

Home Ph. _____ Work Ph. _____ Cell Ph. _____

Dental Insurance

Primary Dental Insurance _____ Employer _____

Subscriber Name _____ ID _____

Subscriber Date of Birth ____/____/____

Secondary Dental Insurance _____ Employer _____

Subscriber Name _____ ID _____

Subscriber Date of Birth ____/____/____

Date _____

Medical History

Are you under a Physician's care for a long term illness? Y ___ N ___

If yes please explain: _____

*Do you premedicate for dental procedures? Y ___ N ___

*Premedicating is a standing order by your attending physician to take antibiotics before ALL dental procedures due to an existing medical condition.

For Women: Are you pregnant? Y ___ N ___ Are you nursing? Y ___ N ___

Have you ever had any of the following diseases or medical conditions?

- | | | | |
|-------------------------|-------------|-----------------------------|-------------|
| Abnormal Bleeding | Y ___ N ___ | Herpes/Fever Blisters | Y ___ N ___ |
| Alcohol/Drug Abuse | Y ___ N ___ | High Blood Pressure | Y ___ N ___ |
| Anemia | Y ___ N ___ | HIV+/AIDS | Y ___ N ___ |
| Arthritis | Y ___ N ___ | Hospitalized for any reason | Y ___ N ___ |
| Asthma | Y ___ N ___ | Kidney Problems | Y ___ N ___ |
| Cancer/Chemotherapy | Y ___ N ___ | Liver Disease | Y ___ N ___ |
| Congenital Heart Defect | Y ___ N ___ | Low Blood Pressure | Y ___ N ___ |
| Diabetes | Y ___ N ___ | Mitral Valve Prolapse | Y ___ N ___ |
| Difficulty Breathing | Y ___ N ___ | Nervous/Anxiety | Y ___ N ___ |
| Emphysema | Y ___ N ___ | Pacemaker | Y ___ N ___ |
| Epilepsy | Y ___ N ___ | Psychiatric Problems | Y ___ N ___ |
| Heart Attack | Y ___ N ___ | Radiation Treatment | Y ___ N ___ |
| Heart Murmur | Y ___ N ___ | Seizures | Y ___ N ___ |
| Heart Surgery | Y ___ N ___ | Sinus Problems | Y ___ N ___ |
| Hemophilia | Y ___ N ___ | Stroke | Y ___ N ___ |
| Hepatitis | Y ___ N ___ | Tuberculosis | Y ___ N ___ |
| Heart Valve Replacement | Y ___ N ___ | Joint Replacement | Y ___ N ___ |

Please list any additional serious medical conditions _____

Are you allergic to any of the following?

- | | | | |
|--------------|-------------|------------|-------------|
| Aspirin | Y ___ N ___ | Latex | Y ___ N ___ |
| Codeine | Y ___ N ___ | Penicillin | Y ___ N ___ |
| Epinephrine | Y ___ N ___ | Sulfa | Y ___ N ___ |
| Erythromycin | Y ___ N ___ | Ibuprofen | Y ___ N ___ |

Please list any additional medicine allergies _____

Are you currently taking or have you ever taken any of the following medications:

- | | | | |
|-----------------------|-------------|------------------------|-------------|
| Zoledronate (Zometa) | Y ___ N ___ | Pamidronate (Aredia) | Y ___ N ___ |
| Clodronate (Bonfos) | Y ___ N ___ | Ibandronate (Boniva) | Y ___ N ___ |
| Risedronate (Actonel) | Y ___ N ___ | Alendronate (Fosamax) | Y ___ N ___ |
| Tiludronate (Skelid) | Y ___ N ___ | Etidronate (Didronel) | Y ___ N ___ |
| Neridronate | Y ___ N ___ | Olpadronate | Y ___ N ___ |
| Reclast | Y ___ N ___ | Alclasta | Y ___ N ___ |
| Denosumab (Prolia) | Y ___ N ___ | | |

Please list any additional medication you are taking _____

Signed _____