Additional Information

Patient Name ____________________________________ Preferred Name ________________ Birthday _____________
Pronouns _______________ Employer _______________________ Occupation _________________________________
HIPAA contact/emergency contact (required to enable us to discuss your account)
Name _______________________________ Relationship _______________________ Phone _______________________

Medical History

(Please circle yes or no)

Has there been any change in your general health within the past year?	Yes	No
Your last physical exam was on (date):		
Are you now under the care of a physician?	Yes	No
Name of your physician:		
Have you had any serious illness, operation, or hospitalization within the past five years?	Yes	No
If yes, for what?		
Are you pregnant?	Yes	No
If yes, due date?		
Does your jaw click out of joint?	Yes	No
Have you ever been told you had periodontal (gum) disease?	Yes	No
Have you ever had periodontal (gum) surgery?	Yes	No
If yes, when?		
Are you taking Coumadin or blood thinner?	Yes	No
Are you taking any anti-anxiety medication?	Yes	No
Do you have a strong gag reflex?	Yes	No
Do you have claustrophobia?	Yes	No

Please list all medications you are currently taking (Attach list if needed) ______________________________

Please circle Yes or No

Heart Murmur	Yes	No
Rheumatic fever	Yes	No
Pacemaker	Yes	No
AIDS or HIV positive	Yes	No
High blood pressure	Yes	No
Low blood pressure	Yes	No
Dizziness or fainting spells	Yes	No
Sinusitis, hay fever, asthma	Yes	No
Diabetes (A1c ______)	Yes	No
Thyroid condition	Yes	No
Bleeding disorders	Yes	No
Psychiatric care	Yes	No
Heart trouble	Yes	No
Artificial Joints	Yes	No

List joint and year of surgery _______________
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Have you recently traveled outside of the United States?
When? _____________Where? _________________

Artificial heart valves	Yes	No
Kidney or bladder trouble	Yes	No
Seizure, epilepsy, convulsion	Yes	No
Anemia	Yes	No
Tuberculosis	Yes	No
Hepatitis (type____)	Yes	No
Yellow jaundice	Yes	No
Venereal disease	Yes	No

Have you ever had an ALLERGIC reaction to:

Local anesthetic (Novocain, xylocaine)	Yes	No
Codeine or similar narcotic	Yes	No
Aspirin	Yes	No
Latex	Yes	No
Barbiturates, tranquilizers, sleeping pills	Yes	No
Penicillin, amoxicillin	Yes	No
Other Antibiotic ____________________	Yes	No

Other allergies _____________________

Patient or guardian signature ____Date ________________