Patient name: ______________________________ **DOB:** ___________________

Are you currently taking any drugs and/or medications? If yes, please list. ☐ Yes ☐ No

____

____

Are you under medical treatment now other than dental treatment? ☐ Yes ☐ No
If so, please explain ____
Have you ever been hospitalized, had a major operation or serious illnesses? ☐ Yes ☐ No

If so, please explain____

Have you ever been told that you need to take an antibiotic prior to dental visits, due to an artificial joint, heart problems, etc… **☐ Yes ☐ No**

Are you allergic to any of the following?

☐ Anesthetics	☐ Latex	☐ Pine Nuts
☐ Penicillin	☐ Tetracycline	☐ Acetaminophen
☐ Amoxicillin	☐ Metals	☐ Iodine
☐ Codeine	☐ Bleach	☐ Aspirin
☐ Sulfa	☐ Pain medications	☐ Augmentin
☐ Bactrim	☐ Vicodin	☐ Ibuprofen

Please include any other allergies not listed above: ____________________________________

Do you, or have you ever had any of the following? (Please check all that apply)

☐ Heart attack	☐ Blood transfusion	☐ Stomach disease	☐ Tuberculosis
☐ Heart ailment or disease	☐ Asthma	☐ Drug abuse/addiction	☐ Chemotherapy
☐ Heart murmur	☐ Intestinal disease	☐ Heart valve implants	☐ Hepatitis
☐ Pacemaker	☐ Liver disease	☐ Mitral valve prolapse	☐ Artificial joint(s)
☐ Stroke	☐ Diabetes	☐ Blood disease	☐ Aids or HIV
☐ Poor blood clotting	☐ Anorexia/bulimia	☐ Hemophilia	☐ Dental Anxiety
☐ Depression	☐ Epilepsy	☐ Respiratory disease	☐ Seizures
☐ Alcohol Abuse/addiction	☐ High Blood Pressure	☐ Venereal disease	☐ Tumors/growths
☐ Osteoporosis	☐ Smoking/chewing tobacco		☐ Other_____________

Are you pregnant? ☐ Yes ☐ No If so, your expected due date is: _____________________

I certify that the information that I have provided is complete and accurate. I understand that it is my responsibility to notify this dental office of any changes prior to initiating any dental treatment.

Patient Signature: ____________________________________ **Date:** ______________________

Provider Signature: ___________________________________ **Date:** ______________________