Patient Personal Information

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Emergency Contact	Emergency Phone #
Email		Student	SSN
Health Care Guardian Name		School Name	
Health Care Guardian Phone #		Referral Type	

Person responsible/guarantor for paying bills

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance? Yes____No___		Do you have Secondary Dental Insurance? Yes____No___	
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information

Allergic To

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Epinephrine

- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Anorexia/Bulimia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Thinners
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease

- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack/Stroke
- ☐ Y ☐ N Heart Murmur/Mitral Valve Prol
- ☐ Y ☐ N Heart Valve Replacement
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N High/Low Blood Pressure

- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis

- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N NSAIDS
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other

Check, if applicable

- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Chemotherapy/Radiation
- ☐ Y ☐ N Congenital Heart Defect/Heart
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters/Herpes
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Lupus
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Pregnant
- ☐ Y ☐ N Premedicate

Other

- ☐ Y ☐ N See Medical Questionnaire

Medical Questionnaire

Emergency Contact

Emergency contact name ______

Emergency contact phone ______

Emergency contact relationship to patient ______

Medical Questionnaire (Please Check Box if "Yes")

Family Physician ______

Phone ______

Are you currently under care of a Physician? ☐

If Yes, what is the condition being treated? ______

Have you had any serious illness, operation or been hospitalized within the past 5 years? ☐

If Yes, what illness or problem? ______

Are you currently taking any medication? ☐

If Yes, what? ______

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) ☐

Have you ever taken the diet control drug Fen-Phen? ☐

Do you use alcoholic beverages? ☐

Do you smoke? ☐

Women Only (Please Check Box if "Yes")

Are you pregnant? ☐

If Yes, what is your due date? ______

Are you currently nursing? ☐

Are you on hormone replacement therapy? ☐

Are you on birth control pills / fertility drugs? ☐

Additional Comments

Any Disease, Condition or Problem not Listed? Please list ______

Pediatric Medical History (Please check box for "YES" if applicable)	
Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions	☐
Problems with physical growth or development	☐
Sinusitis, chronic adenoid/tonsil infections	☐
Sleep apnea/snoring, mouth breathing, or excessive gagging	☐
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	☐
Irregular heart beat or high blood pressure	☐
Asthma, reactive airway disease, wheezing, or breathing problems	☐
Cystic fibrosis	☐
Frequent exposure to tobacco smoke	☐
Jaundice, hepatitis, or liver problems	☐
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	☐
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	☐
Bladder or kidney problems	☐
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	☐
Rash/hives, eczema or skin problems	☐
Impaired vision, hearing, or speech	☐
Developmental disorders, learning problems/delays, or intellectual disability	☐
Cerebral Palsy, brain injury, epilepsy, or convulsions/seizures	☐
Autism/autism spectrum disorder	☐
Recurrent or frequent headaches/migraines, fainting, or dizziness	☐
Attention deficit/hyperactivity disorder (ADD/ADHD)	☐
Behavioral, emotional, communication, or psychiatric problems/treatment	☐
Diabetes, hyperglycemia, or hypoglycemia	☐
Thyroid or pituitary problems	☐
Anemia, sickle cell disease/trait, or blood disorder	☐
Hemophilia, bruising easily, or excessive bleeding	☐
Transfusions or receiving blood products	☐
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant	☐
Mononucleosis, Tuberculosis (TB), Scarlet Fever, or Cytomegalovirus (CMV)	☐
Methicillin resistant staphylococcus aureus (MRSA) or human immunodeficiency virus (HIV)/AIDS	☐

Please provide details for questions answered "YES" ______________________

Additional Comments

Any other significant medical history pertaining to this child or his/her family? ______________________

By signing below, I certify that all the above information is true to the best of my knowledge.

______________________ ______________________

Patient/Guardian Signature **Date**