Applewood
FAMILY DENTISTRY

Patient Name: _____ Date of Birth (MM/DD/YY): _____
Address: _____ Dental Insurance: _____
Name of Parent (If under 18): _____ Primary Care Provider: _____
Phone: _____ Cell: _____ Provider Phone #:_____
Pharmacy: _____ Date of Last Medical Exam: _____

Are you under the care of a Physician:	Yes ☐	No ☐	If Yes, please list date of last visit:
Have you had to stay in the hospital in the last 5 years?	☐	☐	If Yes, please list what date and reason:

Have you had any of the following diseases or problems?	Yes	No	
1. Active Tuberculosis	☐	☐	If Yes, please indicate date of diagnosis:
2. Cough for longer than 3 weeks or a current fever	☐	☐	
3. Cough that produces blood	☐	☐	

>>>>> If you answered "YES" to questions 1, 2 or 3 above please stop and return this form to the receptionist<<<<<

Are you allergic or have you had a bad reaction to any of the following:					
	Yes	No		Yes	No
Local Anesthetics	☐	☐	Metals	☐	☐
Penicillin or other antibiotics	☐	☐	Cloves	☐	☐
Sulfa Drugs	☐	☐	Aspirin	☐	☐
Codeine or other narcotics	☐	☐	Iodine	☐	☐
Latex (rubber)	☐	☐	Hay Fever / Seasonal Allergies	☐	☐
Barbiturates, Sedatives, Sleeping Pills	☐	☐	Other	☐	☐

	Yes	No	
Are you taking any medication? *Including: Prescriptions, Over the Counter Medications, Herbs, Vitamins, Etc.*	☐	☐	If yes, please list your medications:

DO YOU…	Yes	No	HAVE YOU…	Yes	No
Use Recreational Drugs (Past or Present)? If yes, what type_____	☐	☐	Been on any antiresorptive medication or agents (**Bisphosphonates**) to treat Osteoporosis or other skeletal complications? (ex. **Fosomax, Actonel, Atelvia, Boniva, Reclast, Prolla, Aredia, Zometa, XGEVA**)	☐	☐
Use Alcohol: If Yes, how many drinks per week? _____	☐	☐			
Use Tobacco? Chew ☐ Smoke ☐ If Yes, how many packs/day? _____	☐	☐			
Have any bleeding issues or on a blood thinner? (Coumadin, Warfarin, Plavix, Aggrenox, Heparin, Levonox, Prodaxa)	☐	☐	Had cobalt, radium, radiation therapy or chemotherapy?	☐	☐

****PLEASE CONTINUE TO THE BACK OF THIS FORM****

Do you have or have you had any of the following diseases or problems?

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Epilepsy/Seizures	☐	☐	Oral Sores/Ulcers	☐	☐
Aids/HIV Infection	☐	☐	Excessive Urination	☐	☐	Osteoporosis	☐	☐
Alcohol/drug Abuse	☐	☐	Fainting/Dizziness	☐	☐	Pre-medicate before Dental Treatment	☐	☐
Angina (Chest Pain)	☐	☐	Gastric Reflux	☐	☐	Problems after Dental Treatment	☐	☐
Anxiety	☐	☐	Glaucoma	☐	☐	Radiation Therapy	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐	Recent Weight Loss	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Respiratory Problems	☐	☐
Autistic Spectrum Disorder	☐	☐	Hepatitis, Jaundice, Liver Disease	☐	☐	Sexually Transmitted Diseases	☐	☐
Bipolar Disorder	☐	☐	High Blood Pressure	☐	☐	Sleep Disorder	☐	☐
Bleeding Disorder	☐	☐	Joint Replacement or Implant	☐	☐	Stomach Problems	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐
Cardiac Pacemaker or Defibrillator	☐	☐	Leukemia	☐	☐	Swollen Ankles	☐	☐
Diabetes Type I ☐ Type II ☐	☐	☐	Low Blood Pressure	☐	☐	Thyroid Problems	☐	☐
Dry Mouth	☐	☐	Mental Health Disorder	☐	☐	Tuberculosis	☐	☐
Eating Disorder	☐	☐	Multiple Sclerosis	☐	☐	Ulcer	☐	☐
Emphysema	☐	☐	Neck Pain	☐	☐	Other:	☐	☐

Only Heart Conditions Requiring Antibiotic Prophylaxis:	Yes	No	WOMEN ONLY	Yes	No
Artificial Prosthetic Heart Valve	☐	☐	Are you possibly pregnant?	☐	☐
Previous Infective Endocarditis	☐	☐	If Yes, what's the expected due date:		
Damaged Valves in Transplanted Heart	☐	☐	Are you Nursing?	☐	☐
Unrepaired, Cyanotic Congenital Heart Disease	☐	☐	Are you taking Birth Control Pills?	☐	☐
Completely repaired Congenital defect in last 6 months	☐	☐			
Repaired Congenital defect with residual effects	☐	☐			

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately and completely answered. I understand that providing incorrect or misleading information can be dangerous to my health. I am also aware that the clinic should be informed of all my health changes.

_____ _____

Patient/Parent/Guardian Signature Date Doctor Signature Date