Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient, Friend ☐ Another Patient, Relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Medical History Information

Physician: _____ Office Number: _____ Date of Last Exam: _____

Who do we notify in the case of an emergency? _____

1. Are you under medical treatment now? YES NO
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? YES NO
   If YES, please explain: _____
3. Are you taking any medication including non-prescription medicine? YES NO
   If YES, please list medications: _____
4. Have you ever taken Phen-Fen/Redux? YES NO
5. Have you ever taken Fosamax? YES NO
6. Are you taking any Blood Thinners? YES NO
7. Do you use tobacco? YES NO
8. Are you allergic to or have you had any reactions to the following:

Local Anesthetics	Penicillin or any other Antibiotics	Latex Rubber	Other: _____
Sulfa Drugs	Barbiturates	Aspirin	
Sedatives	Iodine	Metals	

10. Have you ever taken Actonel, Aredia (IV), Zometa (IV) or Boniva YES NO
9. Women Only:
   Are you pregnant or think you may be pregnant? YES NO
   Are you nursing? YES NO
   Are you taking oral contraceptives? YES NO

Do you have or have you had any of the following? Please circle those that apply.

High Blood Pressure	Heart Disease	Chest Pains	Heart Attack
Cardiac Pacemaker	Easily Winded	Rheumatic Fever	Heart Murmur
Stroke	Swollen Ankles	Angina	Hay Fever
Allergies	Fainting/Seizures	Frequently Tired	Tuberculosis
Asthma	Anemia	Radiation Therapy	Emphysema
Joint Replacement/Implant	Epilepsy/Convulsions	Cancer	Weight Loss
Glaucoma	Leukemia	Arthritis	Liver Disease
Sexually Transmitted Disease	Diabetes	Heart Trouble	Kidney Disease
Hepatitis A, B, Or C	Jaundice	Respiratory Problems	AIDS/HIV +
Mitral Valve Prolapse	Thyroid Problem	Stomach Trouble	Ulcers
Multiple Myeloma	Metastatic Breast Cancer	Metastatic Prostate Cancer	Osteoporosis

Any other metastatic diseases (Please List)_____

Dental History Information

Reason for Dental Visit Today: _____ Date of Last Dental Visit: _____

1. Do your gums bleed while brushing or flossing? Y/N
2. Are your teeth sensitive to hot or cold liquids/foods? Y/N
3. Are your teeth sensitive to sweet or sour liquids/foods? Y/N
4. Do you feel pain to any of your teeth? Y/N
5. Do you feel pain to any sores or lumps in or near your mouth? Y/N
6. Have you had any head, neck or jaw injuries? Y/N
7. Have you experienced clicking/pain/difficulty in opening, closing or chewing? YES NO
8. Do you have frequent headaches? Y/N
9. Do you clench or grind your teeth? Y/N
10. Do you bite your lips or cheeks frequently? Y/N
11. Have you ever had any difficult extractions? Y/N
12. Have you had any orthodontic treatment? Y/N
13. Do you wear dentures or partials? Y/N
14. Have you ever received oral hygiene instructions? Y/N

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental Care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party