Today's date:_____ Date of Birth:_____

First name_____ Last Name_____

Email Address_____ Social Security Number _____

Street Address:_____
City:_____ State:_____ ZIP_____

Home Phone:_____ Cell Phone_____
Emergency Contact
Name_____
Relation to you _____
Phone Number_____

Are you under the care of a physician now?	Yes	No
Are you in good health?	Yes	No
Have there been any changes in your health in the past year?	Yes	No

If Yes, what condition is being treated? _____
_____

Have you had a serious illness,operation or been hospitalized in the past 5 years?	Yes	No

If yes, what was the illness or problem? _____
_____
Name of Medical Doctor _____
Address_____
Phone Number_____
Date of last visit _____

Preferred Pharmacy_____
Street Address_____
City,State & ZIP _____
Phone Number _____

1. Joint Replacement: Have you had an orthopedic joint (hip, shoulder, knee, finer, elbow etc) replacement?	Yes	No

Date done_____

If YES, have you been told that you need to take an antibiotic premed before your dental appointment?	Yes	No
2. Are you currently taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast or Evista?	Yes	No
3. Do you take a daily Aspirin?	Yes	No
4. Do you take blood thinner, such as Eliquis, Xarelto, Coumadin, Wafarin, Plavix, Clopidogrel, Brilinta, Ticagrelor, Effient, Prasugrel?	Yes	No

Name_____

Allergies- are you allergic to or have you had a reaction to:

Aspirin	Yes	No	NSAID's	Yes	No
Codeine	Yes	No	Nut Allergy	Yes	No
Ibuprofen	Yes	No	Penicillin	Yes	No
Iodine	Yes	No	Amoxicillin	Yes	No
Latex	Yes	No	Red Dye	Yes	No
Local Anesthestic (Dental)	Yes	No	Sulfa	Yes	No
Metals	Yes	No	Foods	Yes	No

Other: _____

Do you have or have had any of the following:

AIDS/HIV	Yes	No
ADD/ADHD	Yes	No
Autism	Yes	No
Aspergers	Yes	No
Alzeheimers	Yes	No
Dementia	Yes	No
Anemia	Yes	No
Anaphylaxis	Yes	No
to what_____		
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Back Problems	Yes	No
COPD	Yes	No
Emphysema	Yes	No
Tuberculosis (TB)	Yes	No
Epilepsy	Yes	No
GI Troubles	Yes	No
Stomach Ulcers	Yes	No
Glaucoma	Yes	No
Headaches	Yes	No
Hearing Impaired	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Osteoporosis	Yes	No
Osteopenia	Yes	No
Parkinsons	Yes	No
Sexually Transmitted Disease	Yes	No
Sickle Cell Disease	Yes	No
Sickle Cell Trait	Yes	No
Sleep Apnea	Yes	No
Uses CPAP machine	Yes	No
Thyroid Disease	Yes	No

Cancer	Yes	No
If yes, what type_____		
When (date)_____		
Radiation Treatment	Yes	No
Chemotherapy	Yes	No
Leukemia	Yes	No
Tumors	Yes	No
If yes, what type_____		
When (date)_____		

Heart/Stroke		
Congestive Heart Disorder	Yes	No
Congenital Heart Disorder	Yes	No
Heart Attack	Yes	No
If yes, when (date)_____		
Heart Surgery	Yes	No
If yes, what type_____		
When (date)_____		
Cardiac Pacemaker	Yes	No
If yes, when (date)_____		
Heart Murmur	Yes	No
Mitral Valve Prolapse(MVP)	Yes	No
Artifical heart valves	Yes	No
Rheumatic Fever	Yes	No
Angina	Yes	No
AFIB	Yes	No
Stroke	Yes	No
If yes, when (date)_____		

Do you smoke?	Yes	No
Do you vape?	Yes	No
Do you chew tobacco?	Yes	No

Name_____

Kidney Disease	Yes	No
Renal Dialysys	Yes	No
If yes, when treatment start_____		

Autoimmune Disease

Hashimotto's	Yes	No
Gout	Yes	No
Rheumatoid Arthritis	Yes	No
Lupus	Yes	No
Other_____		

History of Drug Abuse	Yes	No
History of Alcohol Abuse	Yes	No
Recreational Drug Usage	Yes	No

Diabetes	Yes	No
If Yes, Type 1 or Type 2		
A1C _____ Date_____		
Hypoglycemia	Yes	No

Liver Disease	Yes	No
Hepatitis A	Yes	No
Hepatitis B	Yes	No
Hepatitis C	Yes	No
If yes, has it been treated	Yes	No
Date treated _____		

Bleeding Disorders

Hemophilia	Yes	No
Blood transfusion	Yes	No
If yes, date received _____		
Factor 5 Blood disorder	Yes	No
Any other blood disorder	Yes	No
If yes, please explain _____		
History of blood clots	Yes	No

Are you pregnant?	Yes	No
If yes, due date _____		

Medications or Supplements Currently Taking

Name	Dose	Frequency	Reason for Taking