Patient Name: _____ Birth Date: _____ Date : _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	
Do you use prescription pain medications?	○ Yes ○ No	If yes
Do you use recreational drugs (marijuana, methamphetamines, cocaine, etc)?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

ADHD/ADD ○ Yes ○ No	Cortisone Medication ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Parkinson's/Tremors ○ Yes ○ No
AIDS/HIV Positive ○ Yes ○ No	Dementia ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Psychiatric Care ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Dental Phobia/Anxiety ○ Yes ○ No	Herpes ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Anemia ○ Yes ○ No	Developmental Disorder ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Diabetes ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Rheumatism ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Emphysema ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Shingles ○ Yes ○ No
Asthma/Breathing Problems ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Autism ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Behavioral or Emotional Problems ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Learning Disabilities ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Cancer ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Lung Disease ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Mental Health Disorder ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Communication Problems ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Ulcers ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Hemophilia ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Venereal Disease ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

MILLS & SHANNON DENTISTRY

DATE

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial ____ Preferred Name _____

Physical Address _____ City _____ State ____ Zip Code _____

Mailing Address _____ City _____ State ____ Zip Code _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Birth Date _____ Social Security # _____ Email Address _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other _____

Names of Parents/Guardians (if under 18 years of age) _____

Please list any family members who are also patients here _____

How did you hear about us? _____ Previous Dentist _____

Emergency Contact Name _____ Phone _____

RESPONSIBLE PARTY INFORMATION (IF SOMEONE OTHER THAN THE PATIENT)

First Name _____ Last Name _____ Middle Initial ____

Mailing Address _____ City _____ State ____ Zip Code _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Birth Date _____ Social Security # _____ Email Address _____

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ Policy Holder's Social Security # _____

Policy Holder's Date of Birth _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Name _____ Employer Name Group # _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ Policy Holder's Social Security # _____

Policy Holder's Date of Birth _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Name _____ Employer Name Group # _____