MEDICAL HISTORY FORM

Patient Name: _____ Birth Date: _____

Please check yes or no for the following questions:

Have you seen your primary care physician in the last year? ◯ Yes ◯ No

Are you currently seeing a specialist? ◉ Yes ◯ No If yes what for? _____

Have you ever been hospitalized or had a major operation? ◉ Yes ◯ No

If yes what were you hospitalized for? _____

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 what are you taking? _____

Do you need to premedicate for any dental work or cleanings? ◉ Yes ◯ No

If yes, what condition do you pre-medicate for? _____

Do you have any fear or anxiety regarding seeing the dentist? ◉ Yes ◯ No

Do you use tobacco? ◉ Yes ◯ No If yes, what type? _____

Do you use controlled substances? ◉ Yes ◯ No

Are you pregnant or trying to get pregnant? ◉ Yes ◯ No

Do you have any allergies? Please circle all that apply:

Metal ☐ Latex ☐ Local Anesthetic ☐ Neurotoxins (e.g. Botox or Xeomin) ☐ Dermal Fillers ☐

Antibiotics ☐ If yes: _____

Other ☐ If yes: _____

Is there anything you would like to change about your smile? Please circle all that apply:

Color ☐ Straight Teeth ☐ White Spots ☐ Missing Teeth ☐ Grinding ☐ Staining ☐

Other: _____

Do you have any interest in learning more about Cosmetic Injectables (Botox, Xeomin, Fillers)? ◉ Yes ◯ No

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Do you have, or have you had any of the following? Check all that apply:

AIDS/HIV Positive	◯ Y ◯ N	Alzheimer's Disease	◯ Y ◯ N	Artificial Joint	◯ Y ◯ N
Autoimmune Disease	◯ Y ◯ N	Cancer	◯ Y ◯ N	Cold Sores	◯ Y ◯ N
Drug Addiction	◯ Y ◯ N	Epilepsy/Seizures	◯ Y ◯ N	Excessive Bleeding	◯ Y ◯ N
Frequent Cough	◯ Y ◯ N	Heart Attack/Failure	◯ Y ◯ N	Heart Pacemaker	◯ Y ◯ N
Hepatitis A	◯ Y ◯ N	Hepatitis B or C	◯ Y ◯ N	High Blood Pressure	◯ Y ◯ N
Liver Disease	◯ Y ◯ N	Lung Disease	◯ Y ◯ N	Osteoporosis	◯ Y ◯ N
Liver Disease	◯ Y ◯ N	Recent Weight Loss	◯ Y ◯ N	Sinus Trouble	◯ Y ◯ N
Stroke	◯ Y ◯ N	Thyroid Disease	◯ Y ◯ N	Tuberculosis	◯ Y ◯ N
Pain in Jaw Joints (TMJ)	◯ Y ◯ N	Fainting Spells/ Dizziness	◯ Y ◯ N	Asthma	◯ Y ◯ N
Stomach/Intestinal Disease	◯ Y ◯ N	Heart Trouble/Disease	◯ Y ◯ N	Diabetes	◯ Y ◯ N
Bacterial Endocarditis	◯ Y ◯ N	Kidney Problems	◯ Y ◯ N	Artificial Heart Valve	◯ Y ◯ N

Comments: _____

Signature of Patient, Parent/Guardian: _____ Date_____

PATIENT REGISTRATION FORM

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Date of Birth: _____

Social Security #: _____ Preferred #:

Address: _____ Home Phone: _____ ◯

_____ Cell Phone: _____ ◯

_____ Work Phone: _____ ◯

Email: _____

Would you like to receive e-mail correspondence? ◯YES ◯NO

Would you like to receive text messages? ◯YES ◯NO

Responsible Party Information (If the patient is the responsible party do not fill out the section below):

First Name: _____ Last Name: _____ Middle Initial: _____

Relationship to Patient: ◯Spouse/Partner ◯Parent ◯Child ◯Other: _____

Date of Birth: _____

Social Security #: _____ Preferred #:

Address: _____ Home Phone: _____ ◯

_____ Cell Phone: _____ ◯

_____ Work Phone: _____ ◯

Email: _____

Would you like to receive e-mail correspondence? ◯YES ◯NO

Would you like to receive text messages? ◯YES ◯NO
