Last name: _____ Primary contact no. _____

First name: _____ Alternate contact no. _____

Pronounced/ Preferred name: _____ Email: _____

Date of birth (MM/DD/YY): _____ / _____ / _____ Preferred method of contact: ☐ Primary no.

Address: _____ ☐ Alternate no.

_____ ☐ Text message

_____ ☐ Email

I.C.E. (In Case of Emergency): Contact name: _____

Contact number: _____ Relationship: _____

How did you find out about our office? _____

**HEALTH HISTORY:**

Physician: _____ Contact number: _____

**Allergies:** _____

Current medical conditions/treatments: _____

_____

Current prescription and non-prescription medications (include dosages if known):

_____

_____

Please indicate **Y**es or **N**o the following conditions that apply to you (both currently and past):

Y N **Heart condition** - artificial valve(s), pacemaker, other: _____

Y N **Osteoporosis** – any history with "bone building" medications? _____

Y N **Joint replacement** – which joint(s)? _____

Y N **Organ transplant** – which organ(s)? _____

Y N **Mental health issues** – please specify: _____

Y N **Known communicable disease** – hepatitis, HIV, other: _____

Y N **Respiratory disorder** – asthma, COPD, other: _____

Y N **Diabetes** - Type I or Type II? Controlled? _____

Y N **Smoking history** – how long, how much, etc. _____

Y N **Bleed and/or bruise easily**

Y N **High or low blood pressure**

Y N **Thyroid dysfunction**

Y N **Epilepsy/seizures**

**DENTAL HISTORY (New Patients ONLY):**

Previous **dentist/ location/ approx. date** of last appointment:

_____

Any prior dental experiences you would like us to know about? (difficulty freezing, dental anxiety, surgery, etc.):

_____

_____