NAME _____

LOCAL ADDRESS _____
Number Street City State Zip Code

BILLING ADDRESS _____
(If different than above) *Number Street City State Zip Code*

DATE OF BIRTH _____ SS# _____ EMAIL ADDRESS _____

HOME PHONE _____ MOBILE PHONE _____

MARITAL STATUS _____ SPOUSE (OR S.O) _____ PHONE _____

DENTAL INSURANCE- PRIMARY CARDHOLDERS NAME _____ DATE OF BIRTH _____

SS or ID # _____ INSURANCE COMPANY _____ EMPLOYER or SELF PLAN _____
Present card to receptionist ** Write the name of employer*

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? Our website _____ VB Magazine _____ Internet search _____
Dentist _____ Friend/Family _____

MEDICAL HISTORY

Primary physician _____ Specialty _____

Additional physician _____ Specialty _____

Have you ever been hospitalized or had a major surgery? Why? _____

Have you ever taken Prolia, Fosamax, Boniva, Actonel or any medications containing bisphosphonates? _____

Please list **all** medications _____

_____

_____

Circle all that apply --- Past and Present

AIDS/HIV Positive	Cortisone Medicine	Hepatitis A	Renal Dialysis
Alzheimer's Disease	Diabetes Type I or Type II	Hepatitis B or C	Rheumatic Fever
Anaphylaxis	Drug Addiction	Herpes	Rheumatism
Anemia	Easily Winded	High Blood Pressure	Scarlet Fever
Angina	Emphysema	High Cholesterol	Shingles
Arthritis / Gout	Epilepsy / Seizures	Hives or Rash	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Joint	Excessive Thirst	Irregular Heartbeat	Smoking
Asthma	Fainting Spells / Dizziness	Kidney Problems	Spina Bifida
Autoimmune disease	Frequent Cough	Leukemia	Stomach/Intestinal Issues
Blood Disease	Frequent Diarrhea	Liver Disease	Stroke
Blood Transfusion	Frequent Headaches	Low Blood Pressure	Swelling of Limbs
Breathing Problems	Genital Herpes	Lung Disease	Thyroid Disease
Bruise Easily	Glaucoma	Mitral Valve Prolapse	Tonsillitis
Cancer	Hay Fever	Osteoporosis	Tuberculosis
Chemotherapy	Heart Attack/Failure	Pain in Jaw Joints	Ulcers
Chest Pains	Heart Murmur	Parathyroid Disease	Venereal Disease
Cold Sores / Fever Blisters	Heart Pacemaker	Psychiatric Care	Yellow Jaundice
Congenital Heart Disorder	Heart Trouble/Disease	Radiation Treatments	*Any serious illness not listed:*
Convulsions	Hemophilia	Recent Weight Loss	_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

___Aspirin ___Penicillin / Amoxicillin ___Codeine ___Acrylic

___Metal ___Latex ___Sulfa Drugs ___Local Anesthetics

___ Tetracycline/Minocycline

Do you use controlled substances or have a history of drug abuse? Y / N _____

FOR ELECTRONIC PRESCRIPTIONS:

Pharmacy Name and Location _____

WOMEN: Are You.....

PREGNANT? Y / N NURSING? Y / N TAKING ORAL CONTRACEPTIVES? Y / N

PERSONAL DENTAL HISTORY:

Do you have:

Discomfort at Present?	Y / N	Bleeding Gums when brushing/flossing?	Y / N
Unpleasant taste or odor?	Y / N	Any loose teeth?	Y / N
Sensitive to hot, cold or sweets?	Y / N	Pain with chewing?	Y / N
Spaces developing between teeth?	Y / N	Clicking/popping in jaw joint?	Y / N
Dentures?	Y / N	History of clenching/grinding your teeth?	Y / N

Are you interested in teeth whitening (in office or take home)? Y / N

Are you pleased with the appearance of your teeth? Y / N

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 health. It is my responsibility to inform the dental office of any changes in medical status.

I consent to treatment as necessary or desirable to the care of the patient first named above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, xray, or other services that may be used by the attending doctor, or his assistant or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the financial department.

Signature of Patient, Parent or Guardian:

X_____Date:_____