BROTHERS DENTAL
Caring Family Dentistry

Preferred Name:

Patient's Name	Sex ☐ Male ☐ Female	Date of Birth:	Social Security Number:
Address: (Street & Apartment #)	**Patient Is:**	Home Phone: ( )	Cell Phone: ( )
Address:(City, State & Zip)	☐ Minor ☐ Married	Employed ☐ Full Time ☐ Part Time ☐ Retired	Employer:
EMAIL:	☐ Single ☐ Student	Whom May We Thank for Referring You?	Employer Phone: ( )
Spouse's or Parent's Name (If Patient is a Minor)	☐ Widowed	Emergency Contact Name:	Emergency Contact Phone: ( )

How do you PREFER to be CONFIRMED?Mark ALL THAT APPLY: EMAIL _____ Home_____ CELL_____Work_____ Text______

MEDICAL HISTORY

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? O Yes O No If yes, please explain:______________________________

If Yes , What is Physicians Name ________________________ Phone #________________________

Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:______________________________

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:______________________________

Have you ever taken Fosamax, Boniva, Actenol or any other medication containing Bisphosphonates? O Yes O No If yes, please explain:______________________________

Are you on a special Diet? O Yes O No If yes, please explain:______________________________

Do you use tobacco? O Yes O No If yes, please explain:______________________________

Do you use any controlled substances? O Yes O No If yes, please explain:______________________________

WOMEN: Are You

Pregnant/ trying to get pregnant? O Yes O No # of weeks_____________ Taking Birth Control? O Yes O No Nursing? O Yes O No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

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

☐ Other? If yes, Please explain: ______________________________

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

Condition		Condition		Condition		Condition	
Abnormal Bleeding	O Yes O No	Fainting Spells/ Dizziness	O Yes O No	Rheumatic Fever	O Yes O No	Heart Murmur	O Yes O No
Alcohol Abuse	O Yes O No	Frequent Headaches	O Yes O No	Shingles	O Yes O No	Heart Disease	O Yes O No
Allergies/Hay Fever	O Yes O No	Glaucoma	O Yes O No	Sickle Cell Disease	O Yes O No	Herpes	O Yes O No
Anemia	O Yes O No	Heart Attack	O Yes O No	Sinus Problems	O Yes O No	High Cholesterol	O Yes O No
Angina Pectoris	O Yes O No	Heart Surgery	O Yes O No	Stroke	O Yes O No	Leukemia	O Yes O No
Arthritis	O Yes O No	Hemophilia	O Yes O No	Thyroid Problems	O Yes O No	Osteoporosis	O Yes O No
Artifical Bones/Joints	O Yes O No	Hepatitis A	O Yes O No	Tuberculosis	O Yes O No	Pain in Jaw Joints	O Yes O No
Artifical Heart	O Yes O No	Hepatitis B	O Yes O No	Ulcers	O Yes O No	Parathyroid Disease	O Yes O No
Asthma	O Yes O No	Hepatitis C	O Yes O No	Venereal Disease	O Yes O No	Renal Dialysis	O Yes O No
Blood Transfusion	O Yes O No	High Blood Pressure	O Yes O No			Stomach/ Intestinal	O Yes O No
Cancer/ Chemo	O Yes O No	HIV/ AIDS	O Yes O No	Acid Reflux	O Yes O No	Swelling of Limbs	O Yes O No
Colitis	O Yes O No	Kidney Problems	O Yes O No	Alzheimers Disease	O Yes O No	Taking medication for	
Congenital Heart	O Yes O No	Liver Disease	O Yes O No	Anaphylaxis	O Yes O No	weight control	O Yes O No
Cosmetic Surgery	O Yes O No	Low Blood Pressure	O Yes O No	Blood Disease	O Yes O No	Taking dietary	
Diabetes	O Yes O No	Mitral Valve	O Yes O No	Blood Thinners	O Yes O No	supplements	O Yes O No
Difficulty Breathing	O Yes O No	Pace Maker	O Yes O No	Bruise Easily	O Yes O No	Tumors or Growths	O Yes O No
Drug Abuse	O Yes O No	Pneumocystis	O Yes O No	Chest Pains	O Yes O No	Trouble Sleeping	O Yes O No
Emphysema	O Yes O No	Psychiatric Problems	O Yes O No	Radiation Treatments	O Yes O No	Other:	O Yes O No
Epilepsy/Seizures	O Yes O No	Radiation Therapy	O Yes O No	Cortisone Medicine	O Yes O No		

List of any Current Medications Taking: ______________________________

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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 ______________________________DATE ____________________