HOW DID YOU HEAR ABOUT US?

○ GOOGLE ○ DRIVE BY ○ FACEBOOK ○ WEBSITE
○ EXISTING PT ○ ANOTHER OFFICE ○ INS DIRECTORY
○ SIGN ○ OTHER_____

BLUE CEDAR DENTISTRY

PATIENT INFORMATION

DATE_____ **NAME**_____ **ADDRESS**_____ _____ **PLACE OF EMPLOYMENT**_____ **DENTAL INS CARRIER**_____	**DOB**_____ **SSN**_____-_____-_____ **PHONE** _____ **EMAIL** _____ ***EMERG CONTACT*** **NAME**_____#_____

Although dental personnel treat the area in and around your mouth, your mouth is 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 receive. Thank you for answering the following questions to the best

Are you under a physician's care no	○ yes ○	**If yes, please explain**
Have you ever been hospitalized or had a major surgery no	○ yes ○	**If yes, please note**
Have you ever had a serious head or neck injury	○ yes ○	**If yes, please note**
Are you taking any medications, pills, or drugs no	○ yes ○	**If yes, please list** _____ ___ _____ ___
Do you have any artificial joints no	○ yes ○	**If yes, list joint and month/year of replacement**
Are you or have you taken a osteoporosis medication no	○ yes ○	**If yes, please list**
Are you on a special diet	○ yes ○	
Do you use tobacco	○ yes ○	
Do you use a controlled substances	○ yes ○	

Women Only: **Pregnant/Trying** ○ yes ○ no **Nursing** ○ yes ○ no **Taking Birth Control** ○ yes ○ no

ARE YOU ALLERGIC TO ANY TO THE FOLLOWING: ○ Penicillin ○ Sulfa Drugs ○ Aspirin ○ Codeine ○ Anesthetics ○ Metal

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING

o AID/HIV POSITIVE	o CORTISONE MEDIICINE	o HEMOPHILIA	o RADIATION TREATMENT
o ALZHEIMER'S	o DIABETES	o HEPATITIS A	o RECENT WEIGHT LOSS
o ANAPHYLAXIS	o DRUG ADDICTION	o HEPATITIS B OR C	o RENAL DIALYSIS
o ANEMIA	o EASILY WINDED	o HERPES	o RHEUMATIC FEVER
o ANGINA	o EMPHYSEMA	o HIGH BLOOD PRESSURE	o SCARLET FEVER
o ARTHRITIS/GOUT	o EPILEPSY/SEIZURES	o HIGH CHOLESTEROL	o SHINGLES
o ARTIFICIAL HEART VALVE	o EXCESS BLEEDING	o HIVES/RASH	o SICKLE CELL DISEASE
o ARTIFICIAL JOINT	o EXCESS THIRST	o HYPOGLYCEMIA	o SINUS TROUBLE
o ASTHMA	o FAINTING/DIZZY SPELLS	o IRREGULAR HEARTBEAT	o SPINA BIFIDA
o BLOOD DISEASE	o FREQUENT COUGH	o KIDNEY ISSUES	o STOMACH/INTESTINE DISEASE
o BLOOD TRANSFUSION	o FREQUENT DIARRHEA	o LEUKEMIA	o STROKE
o BREATHING PROBLEM	o FREQUENT HEADACHES	o LIVER DISEASE	o SWELLING OF LIMBS
o BRUISE EASILY	o GENITAL HERPES	o LOW BLOOD PRESSURE	o THYROID DISEASE
o CANCER	o GLAUCOMA	o LUNG DISEASE	o TONSILITIS
o CHEMOTHERAPY	o HAY FEVER	o MITRAL VALVE PROLAPSE	o TUBERCULOSIS
o CHEST PAINS	o HEART ATTACK/FAILURE	o OSTEOPOROSIS	o TUMORS OR GROWTH
o COLD SORES/ FEVER BLISTERS	o HEART MURMUR	o PAIN IN JAW	o ULCERS
o CONGENITAL HEAR DISORDER	o HEART PACEMAKER	o PARATHYROID DISEASE	o VENEREAL DISEASE
o CONVULSIONS	o HEART DISEASE	o PSYCHIATRIC CARE	o YELLOW JAUNDICE
ANY OTHER SERIOUS ILLNESS NOT LISTED:			

TO THE BEST OF MY KNOWLEDGE THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

PATIENT/LEGAL GUARDIAN_____ DATE_____