



GREEN PARK

DENTISTRY

FIRST NAME	LAST NAME	ADDRESS (PO & STREET)	HOME PHONE
CITY	STATE	ZIP CODE	CELL PHONE
BIRTHDATE	SS#	EMPLOYER	WORK PHONE
DENTAL INSURANCE COVERAGE		NAME OF INSURED IF DIFFERENT THAN PATIENT	
INSURED BIRTHDATE		INSURED SS#	
REFERRED BY (Circle One) Yellow Pages TV Friend / Family Location/Sign Direct Mail Internet		NAME / PHONE # OF EMERGENCY CONTACT NOT LIVING WITH YOU	
SPOUSES NAME BIRTH DATE		EMPLOYER	WORK / CELL PHONE

LAST PHYSICAL EXAMINATION WAS ON _____

NAME OF YOUR PHYSICIAN _____

LAST DENTAL CLEANING WAS ON _____

HAVE YOU BEEN TREATED OR ARE YOU CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING? (CIRCLE)

- | | | |
|--------------------------|------------------------|------------------------------|
| ABNORMAL BLEEDING | DIABETES | PAINFUL / SWOLLEN JOINTS |
| AIDS OR HIV INFECTIONS | EMPHYSEMA | PERSISTENT COUGH |
| ANEMIA | EPILEPSY | PERSISTENT DIARRHEA |
| ANGINA | FAINTING SPELLS | RADIATION/CHEMOTHERAPY |
| ANKLE SWELLING | HAY FEVER | RECENT WEIGHT LOSS |
| ARTERIOSCLEROSIS | HEART ATTACK | REPLACEMENT HIP/KNEE |
| ARTHRITIS | HEART MURMUR | RESPIRATORY PROBLEMS |
| ARTIFICIAL HEART VALVES | HEART TROUBLE | RHEUMATIC HEART DISEASE |
| ASTHMA | HEPATITIS A B C | SEIZURES |
| BLOOD TRANSFUSION | HIGH BLOOD PRESSURE | SEXUALLY TRANSMITTED DISEASE |
| BRONCHITIS | HYPERACIDITY | SHORTNESS OF BREATH |
| CANCER | IMMUNE SYSTEM PROBLEMS | SINUS TROUBLES |
| CARDIAC PACEMAKER | INBORN HEART DEFECTS | SLEEP APNEA |
| CARDIOVASCULAR DISEASE | JAUNDICE | STOMACH ULCER |
| CHEMOTHERAPY/RADIATION | KIDNEY DISEASE | STROKE |
| CHEST PAIN UPON EXERTION | LOW BLOOD PRESSURE | SWOLLEN GLANDS IN NECK |
| CORONARY INSUFFICIENCY | MENTAL HEALTH PROBLEMS | THYROID PROBLEMS |
| CORONARY OCCLUSION | NEUROLOGICAL DISEASE | TUBERCULOSIS |
| DAMAGED HEART VALVES | | VERTIGO |

- YES NO 1. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? _____
- YES NO 2. HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION OR BEEN HOSPITALIZED IN THE PAST 5 YEARS? IF SO, WHAT WAS THE ILLNESS OR PROBLEM? _____
- YES NO 3. ARE YOU CURRENTLY TAKING ANY MEDICATIONS AT THIS TIME?
PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING. INCLUDE ANY HERBAL VITAMINS,
PRESCRIPTION MEDICINE, OR OVER THE COUNTER MEDICINES

- YES NO 4. HAVE YOU EVER TAKEN FOSAMAX, ACTONEL, BONIVA OR ANY OTHER BISPSPHONATE
MEDICATIONS?
- YES NO 5. LIST ANY KNOWN DRUG ALLERGIES _____
- YES NO 6. ARE YOU ALLERGIC TO ANY METALS? _____ TYPE _____
- YES NO 7. HAVE YOU EVER HAD A SKIN REACTION TO JEWELRY?
- YES NO 8. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM, NOT LISTED ABOVE THAT WE SHOULD BE
AWARE OF? _____
- YES NO 9. ARE YOU PREGNANT OR NURSING? _____
- YES NO 10. ARE YOU TAKING BIRTH CONTROL? _____
- YES NO 11. DO YOU USE ANY FORM OF TOBACCO? _____ HOW MANY YEARS? _____
- YES NO 12. DO YOU DRINK SOFTDRINKS?
- YES NO 13. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT?
IF SO, PLEASE EXPLAIN _____
- YES NO 14. DO YOUR GUMS BLEED? _____
- YES NO 15. HAVE YOU NOTICED ANY GUM SWELLING AROUND ANY TEETH? _____
- YES NO 16. WOULD YOU LIKE WHITER TEETH? _____
- YES NO 17. ARE YOU DISSATISFIED WITH YOUR TEETH AND THEIR APPEARANCE? _____
- YES NO 18. WHEN WAS YOUR LAST DENTAL TREATMENT? _____
- YES NO 19. WHAT IS YOUR PRESENT DENTAL PROBLEM? _____
- YES NO 20. DO YOU TAKE RECREATIONAL DRUGS? _____
- YES NO 21. MAY WE TEXT YOU FOR APPOINTMENT REMINDERS? PHONE# _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE FORM. I ACKNOWLEDGE THAT MY QUESTIONS IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY STAFF MEMBER, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM. I AM ALSO AWARE THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT.

SIGNATURE

TODAYS DATE

EMAIL ADDRESS:

PLEASE UNDERSTAND THAT OUR OFFICE WILL ONLY USE YOUR EMAIL ADDRESS FOR ELECTRONIC STATEMENTS AND CONFIRMATION OF YOUR UPCOMING APPOINTMENT.