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