Please take a few minutes to UPDATE your contact information & health and dental histories.

PATIENT INFORMATION

NAME _____ **BIRTH DATE**_____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

EMAIL_____

HOME PHONE_____ **WORK PHONE**_____

CELL PHONE_____ **Are texts accepted? (please circle)** **YES** **NO**

WHAT IS THE BEST WAY TO CONTACT YOU? (please circle one)

Home phone Cell phone Work Phone Email

CAN WE CONFIRM YOUR APPOINTMENTS THROUGH : (circle all appropriate)

Text Email Phone

DO YOU HAVE DENTAL INSURANCE? **YES** **NO**

PATIENT DENTAL HISTORY

Please answer YES or NO to the following & provide explanation if necessary

Do you have:	YES	NO	EXPLAIN
Pain/Sensitivity in any of your teeth?	____	____	_____
Bleeding when you brush or floss?	____	____	_____
Clicking, popping or aching in your jaw?	____	____	_____
Problems with previous dental work?	____	____	_____
Do you currently wear a bite guard?	____	____	_____
Do you have any interest in:			
Whitening your teeth?	____	____	_____
Changing the appearance of your teeth?	____	____	_____

Is there anything else you would like us to know about you and/or your health?

_____

_____

PATIENT MEDICAL HISTORY

- Are you required to take PREMEDICATION antibiotics before dental treatment? YES NO
- Have you ever taken ***bisphosphonates*** (often given for osteoporosis)? YES NO
  Examples: *Aclasta/Zometa, Actonel, Aredia, Boniva, Fosamax, Reclast*
- Do you use tobacco? YES NO
- Women ONLY: (*please circle)*
  Are you currently: PREGNANT NURSING TAKING BIRTH CONTROL PILLS
- Are you taking medications (prescription, over the counter, supplements)? YES NO

  Please list all medications taken:_____

  _____

DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING?

PENICILLIN/AMOXICILLIN	YES	NO	SULFA	YES	NO
CEPHALOSPORINS (KEFLEX)	YES	NO	LATEX	YES	NO
OTHER MEDICATIONS (please list)	YES	NO	_____		

PLEASE INDICATE IF YOU **HAVE OR HAVE HAD** ANY OF THE FOLLOWING CONDITIONS:

	YES	NO	EXPLAIN/SPECIFY
HEART PROBLEMS	____	____	_____
HIGH BLOOD PRESSURE	____	____	Medication taken: _____
STROKE	____	____	Date: _____
ASTHMA	____	____	Medication taken: _____
LUNG DISEASE	____	____	_____
SEIZURES	____	____	_____
HEPATITIS A, B, OR C	____	____	Specify type: _____
LIVER DISEASE	____	____	_____
KIDNEY DISEASE	____	____	_____
DIABETES	____	____	Medication taken: _____
THYROID PROBLEMS	____	____	High or low? _____
ARTHRITIS	____	____	_____
JOINT REPLACEMENT	____	____	Date/Location: _____
AIDS/HIV	____	____	_____
CANCER	____	____	Date/Type: _____
CHEMO/RADIATION THERAPY	____	____	Date: _____
GERD (ACID REFLUX)	____	____	Medication taken: _____
SLEEP APNEA	____	____	CPAP used? _____
OTHER	____	____	_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

PRINT NAME	SIGNATURE	DATE

OFFICIAL USE ONLY:

Sharla Aronson, DDS		
DENTIST	SIGNATURE	DATE