Name:_____Preferred Name:_____

Address: _____

City: _____State: _____ Zip: _____

Cell Phone: _____ H or W phone: _____

Email address: _____

Place of employment: _____ Birthdate: _____ Sex: _____

Marital Status: _____ Name of Responsible Party: _____

Who may we thank for referring you? _____

Who is your General Dentist: _____

Pharmacy Name/Number: _____ Emergency Contact: _____

Dental History

1. Are you happy with the appearance of your teeth? _____Yes _____No
2. Are you able to eat whatever you want and function comfortably with your teeth? _____Yes _____No
3. What changes or improvements would you like to have for your smile? _____

_____

4. What is the reason for your visit to our office today? _____

_____

Health History

1. Are you in general good health? ..... _____Yes _____No
2. Have you ever been hospitalized for any illness or operation? ..... _____Yes _____No
3. Are you taking antibiotics, sulfa drugs, or anticoagulants? ..... _____Yes _____No
4. Are you taking blood pressure medicine tranquilizers or iodine? ..... _____Yes _____No
5. Are you taking codeine, narcotics, or any other drug? ..... _____Yes _____No
6. Do you wear glasses and/or contacts? ..... _____Yes _____No
7. Do you drink alcohol? ..... _____Yes _____No
8. Do you smoke or use smokeless tobacco? ..... _____Yes _____No
9. Are you pregnant or nursing? ..... _____Yes _____No
10. Do you have any menstrual problems, take oral contraceptives, or are you on hormone therapy? ..... _____Yes _____No
11. Are you experiencing oral pain, headaches, earaches, or neck pains? ..... _____Yes _____No
12. Are you currently or have you ever taken bisphosphonates (drugs like Actonel, Fosamax, etc. to increase bone density)?... _____Yes _____No
13. Please list all medications (prescription and over the counter), dosage, and reason for taking.

_____

_____

Please circle any of the following that you have had or presently have:

Abnormal Bleeding/surgery	Emphysema	Osteoporosis
AIDS/HIV infected	Epilepsy/seizures/fainting spells Pacemaker	Persistent cough or cold
Anemia	Family history of blood disorders	Sexually transmitted disease
Arthritis	Glaucoma	Shortness of breath on exertion
Asthma	Heart Attack/trouble/damaged valve	Sickle Cell
Blood Pressure Problems	Hepatitis A,B,C,D	Sinus Trouble
Blood Transfusion	Hemophiliac	Heart Murmur
Chemotherapy	Herpes	Stomach Ulcers
Chronic Bronchitis	Hyper/Hypo thyroidism	Stroke
Congenital/Rheumatic heart disease	Joint replacement	Kidney trouble
Coronary insufficiency	Tuberculosis	Tumors/Malignancy
Diabetes	Liver Disease	Vomited Blood
Emotional disturbances		

Please list any medical conditions or diseases not circled above:

_____

Are you allergic to or have you reacted adversely to any of the following:

Aspirin	Codeine	Erythromycin	Penicillin	Sleeping Pills
Barbiturates	Dental anesthetics	Iodine	Sedatives	Sulfa Drugs

Please list any known drug or other allergies not circled above: _____

_____

Upon acceptance of treatment, I hereby authorize and request the performance of dental services for myself. I also give my consent to any advisable dental procedures, medications or anesthetics to b e administered by Dr. Ken Parrish or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photos, x-rays and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself regardless of insurance coverage. I give Dr. Ken Parrish permission to use any photographs or other dental records for display or for instruction with other dentists who may be in training. To the best of my knowledge, the information provided is an accurate disclosure of my complete medical history. I will immediately inform of the office of any changes to my medical history or status."

Signed: _____Date_____