Patient Information	
Patient Name:	**Home Phone Number:**
Date of Birth:	**Cell Phone Number:**
Home Address:	**Email Address:**

Patient Medical History		
Questions:		**Answers:**
Are you under any medical treatment now?	If yes, please indicate in answer box:	
Are you taking any medications, including non-prescription medicine?	If yes, please list the medications in answer box:	
Do you have any medical or food allergies?	If yes, please list the your allergies in answer box:	
Have you been hospitalized for any surgical operation or serious illness?	If yes, please put the reason in the answer box:	
Have you had a Knee, Hip or Joint Replacement or Implant?	If yes, please indicate which and why in the answer box:	
*How long ago was the procedure?	Please indicate in the answer box:	
*Do you have any pins/plates/screws?	If yes, please indicate which and where in answer box:	
Do you take any form of blood thinners? (even if its regularly or occasionally)	If yes, please list the medications in answer box:	
Have you have anxiety and need a pre-med before being seen?	If yes, please indicate what medication in the answer box:	
Do you have dentures? Complete or Partials?	If yes, please indicate in answer box:	
Do your gums bleed while brushing?	If yes, please indicate in answer box:	
Do you have any sensitivity?	If yes, please indicate in answer box:	
Do you clench or grind your teeth?	If yes, please indicate in answer box:	
Do you have Low/High Blood Pressure?	If yes, please indicate in answer box:	
Do you have a pacemaker?	If yes, please indicate how long ago it was placed in answer box:	
Do you have Hepatitis?	If yes, please indicate in answer box:	
Have you been exposed to a Sexually Transmitted Disease?	If yes, please indicate and how long ago in answer box:	
Do you have AIDS?	If yes, please indicate in answer box:	
Are you HIV positive?	If yes, please indicate in answer box:	
Do you have Cancer?	If yes, please indicate in answer box:	

LEGAL	
I hereby read and filled out the form to the best of my knowledge.	
X	
Signature	Date
X	