ELITE DENTAL SPECIALISTS

Patient Name:	Date of Birth:	Today's Date:

Are you under a physician's care now?	☐ Yes	☐ No	If yes:
Have you ever been hospitalized or had surgery?	☐ Yes	☐ No	If yes:
Are you taking any medications, pills or drugs?	☐ Yes	☐ No	If yes:
Have you ever taken bisphosphonate medications?	☐ Yes	☐ No	If yes:
Do you currently smoke?	☐ Yes	☐ No	

Women are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Latex ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine

☐ Local Anesthetics ☐ Metal

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Hemophilia	☐ Diabetes
☐ High Blood Pressure	☐ Epilepsy or Seizures	☐ Angina
☐ Excessive Bleeding	☐ Hives or Rash	☐ Pain in Jaw Joints
☐ Hypoglycemia	☐ Asthma	☐ Artificial Joint
☐ Kidney Problems	☐ Emphysema	☐ Fainting/Dizziness
☐ Herpes	☐ Stomach/Intestine Disease	☐ Liver Disease
☐ Congential Heart Disease	☐ Cancer	☐ Thyroid Disease
☐ Artificial Heart Valve	☐ Heart Attack/Failure	☐ Osteoporosis
☐ Irregular Heart Beat	☐ Heart Pacemaker	☐ Ulcers

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes to my medical status.

Signature of Patient, Parent or Guardian:

Date: