Morristown Family Dentistry

Patient Name ______________________________ Preferred Name ____________________
First Middle Last

SS# __________________ Birthdate ______________ Age ________ Sex: M or F

Home Address ____ Zip ____________

Cell (_________)______________ Home (_________)______________ Work (_________)______________

E- Mail Address ______________________________ Preferred contact (please circle) text email call

Marital Status __________ Spouse's Name ________________ Referred By ________________

Emergency contact ________________ Relationship __________ Contact #______________

Dental Insurance YES NO With whom? ________________ Employer ________________

Reason for visit ______________________________ Date of last cleaning ______________

Are you happy with your smile? YES NO If no, what would you change? ______________________________

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

- Acid Reflux........................ Yes No
- ADHD........................ Yes No
- Arthritis........................ Yes No
- Artificial Joints........................ Yes No
  - (Replacement Date and Type____________________)
- Asthma........................ Yes No
- Autism........................ Yes No
- Cancer........................ Yes No
  - (Diagnosis Date and Type____________________)
- Cardiovascular disease........................ Yes No
- Celiac Disease........................ Yes No
- Congenital heart lesions........................ Yes No
- Dementia/ Alzheimer's........................ Yes No
- Diabetes........................ Yes No
- Eating Disorder........................ Yes No
- Fainting spells or seizures........................ Yes No
- Hay fever........................ Yes No
- Hepatitis, jaundice or liver disease.... Yes No
- High Blood Pressure........................ Yes No
- HIV/AIDS........................ Yes No
- Low Blood Pressure........................ Yes No
- Psychiatric counseling........................ Yes No
- Rheumatic fever........................ Yes No
- Serious head, neck, or jaw injury........ Yes No
  - (Date and Type____________________)
- Sleep Apnea........................ Yes No
  - (Do you wear a CPAP?______________)
- Substance abuse (alcohol, drugs)........ Yes No
- Tobacco use........................ Yes No
- Venereal disease........................ Yes No
- Mitral Valve Prolapse........................ Yes No

List any other major illness or injury not mentioned ______________
____

Describe any heart condition______________________________

Have you ever experienced abnormal bleeding following a cut or extraction? Yes No
If so, explain______________________________________

Females: Are you taking birth control................................. Yes No

Are you currently or could possibly be pregnant? Yes No

If yes, what is your due date:______________

Are you **currently** taking**:**

- Antibiotics........................ Yes No
- Anticoagulants or blood thinner........................ Yes No
- High blood pressure medication........................ Yes No
- Cortisone, steroids or ACTH........................ Yes No
- Sleep medication........................ Yes No
- Insulin........................ Yes No
- Tranquilizers or sedatives........................ Yes No

Have you **ever** taken:

- Fen-Phen........................ Yes No
- Fosamax or a "shot for your bones"........................ Yes No

Have you been told by a doctor that you are required to take antibiotics prior to treatment?........................ Yes No

List all current medications (including any over the counter):

____
____
____

Pharmacy Name, Address, and Phone

____
____

Are you **ALLERGIC TO** or have you reacted adversely to?

- Anticoagulants or blood thinner........................ Yes No
- Aspirin........................ Yes No
- Barbiturates, sedatives or sleeping pills........................ Yes No
- Codeine........................ Yes No
- Iodine........................ Yes No
- Latex........................ Yes No
- Local anesthetics........................ Yes No
- Nickel........................ Yes No
- Penicillin........................ Yes No
- Other________________________________

I hereby consent to all visits necessary to receive an oral evaluation, dental treatment and maintenance treatment and for the release of information of health conditions to official agencies and/or private doctors. To the best of my knowledge, the medical history is true and accurate. I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

SIGNATURE__________________________Date ____________

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.