174 Community Park Road Dyersburg, TN 38025
Office: 731-285-8890

Date: ______________________________
Patient Name: ____________________________________ Age: ________
Medical Physician: __________________________ Office#:(___)________________
Address: ____
Street City State Zip

Date of Last Physical: ________________________ Who was the last dentist who cared for your teeth? ___________________

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years? If yes, explain: ☐ Yes ☐ No

____
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3. Are you taking any medication(s) including non-prescription medicine and/or herbal supplements? If yes please list. (use lines below if necessary)

____
____

4. Do you use tobacco? ☐ Yes ☐ No
5. Do you use alcohol regularly? ☐ Yes ☐ No
6. Do you use any illegal drugs? ☐ Yes ☐ No
7. Have you used any illegal drugs in the past? ☐ Yes ☐ No
8. Have you used IV. drugs? ☐ Yes ☐ No
9. Are you wearing contact lenses? ☐ Yes ☐ No
10. Are you taking any blood thinners? ☐ Yes ☐ No
11. Do you take aspirin daily? ☐ Yes ☐ No
12. Are you taking any birth control medication? ☐ Yes ☐ No

Medications: ______________________________
____
____

14. Are you allergic to or have reactions to the following:

☐ Local Anesthetics (e.g. Novocain)
☐ Penicillin
☐ Other Antibiotics
☐ Sulfa Drugs
☐ Barbiturates
☐ Sedatives
☐ Iodine
☐ Codeine
☐ Any Metal (e.g. Nickel, Mercury, ect.)
☐ Latex Rubber
☐ Other (please list) ________________

15. Women Only:
Are you pregnant, or think you may be? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No
Are you taking any osteoporosis medications? ☐ Yes ☐ No

13. Do you have, or have you ever had, any of the following? (Check √ the box if it applies to you)

☐ Rheumatic Fever
☐ Rheumatic Heart Disease
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Artificial Joints or Implants
☐ Artificial Heart Valves
☐ Organ Transplant
☐ Heart Attack
☐ Stroke
☐ Cardiac Pacemaker
☐ Heart Disease / Trouble
☐ Angina / Chest Pains
☐ Cancer / Radiation Therapy
☐ Bleeding / Clotting Disorder
☐ Sickle Cell Anemia
☐ Leukemia
☐ AIDS / HIV Infection
☐ Hepatitis / Jaundice, What type:
☐ Liver Disease
☐ Diabetes, Insulin Dependent:
☐ Kidney Disease
☐ Low / High Blood Pressure
☐ Asthma
☐ Tuberculosis
☐ Emphysema / COPD
☐ Respiratory Disease
☐ Epilepsy / Convulsions
☐ Sexually Transmitted Disease
What: ________________________
☐ Glaucoma
☐ Stomach Trouble / Ulcers
☐ Thyroid Disorder
☐ Arthritis
☐ Osteoporosis
☐ Paget's Disease
☐ Other: ______________________

Your Pharmacy Information
Rx Name: ________________________
City: __________________ State: ______
Phone #(___)______________________
(in case prescriptions need to be phoned in for you)

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be financially responsible for payments for all services rendered at each appointment on my behalf to my dependents. In the event that my payment is not received within 90-days of it's due date. I agree to pay all costs of collection, including, but not limited to reasonable attorney's fees.

X____
Patient signature and/or financially responsible party (parent or guardian if a minor)