Link the Valley

TODAY'S DATE______________________________

NAME___________________________________ DATE OF BIRTH_______________ AGE____ M__F__

ADDRESS__________________________________________ PHONE #___________________________

__________________________________________ SS#_____________________________

FAMILY PHYSICIAN'S NAME/ADDRESS________________________________________________________

________________________________________________________

INSURANCE COMPANY NAME_____________________________________

POLICY ID#______________________________

POLICY HOLDER'S NAME____________________________________

POLICY HOLDER'S SS#_____________________

POLICY HOLDER'S RELATIONSHIP TO PATIENT______________________________________

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS?________ IF YES, PLEASE EXPLAIN

_________________________________________________________________________________

DO YOU BLEED EXCESSIVELY WHEN CUT?___________________

DO YOU SMOKE?______________ HOW MUCH?______________________________________________

DO YOU USE TOBACCO CHEW OR SNUFF?__________ HOW OFTEN?______________________________

WHICH PRESCRIPTION AND/OR NON-PRESCRIPTION MEDICATIONS ARE YOU CURRENTLY TAKING?________________________________________________________________________________

PLEASE **"X"** ANY OF THE FOLLOWING CONDITIONS THAT YOU **HAVE** OR **HAVE HAD**:

____HEART DISEASE ____ANXIETY ____CHRONES

____RHEUMATIC FEVER ____HIGH BLOOD PRESSURE ____DIABETES

____STROKE ____HEART MURMUR ____ARTHRITIS

____TUMOR HISTORY ____RADIATION TREATMENT ____EPILEPSY

____LIVER DISEASE ____VENEREAL DISEASE ____HEPATITIS ( A, B, C)

____BLOOD DISEASE ____KIDNEY DISEASE ____HIV POSITIVE____AIDS

____SHORTNESS OF BREATH ____TUBERCULOSIS ____ASTHMA

____ADD/ADHD ____ALCOHOLISM ____SEIZURES

____ULCERS ____AUTISM SPECTRUM ____STD ___________________

____JOINT REPLACEMENT: ____CANCER ____SUBSTANCE USE: ____OPIOIDES

____HAVE YOU EVER TAKEN PREMEDS (ANTIBIOTICS) BEFORE DENTAL WORK AFTER JOINT REPLACMENT SURGERY

HAVE YOU EVER TAKEN BISPHOSPHONATES (FOSAMAX, ACTONEL, BONIVA, AREDIA, ZOMETA, DIDRONEL OR SKELID) FOR OSTEOPOROSIS OR MALIGNANCY?___________________________

CHEMO OR PRE-CHEMO MEDS?_______________________________________________________

OTHER (PLEASE EXPLAIN)__________________________________________________________________

ARE YOU ALLERGIC TO:

-PENICILLIN_____________ -LOCAL ANESTHETICS__________________________________________

-ANTIBIOTICS (PLEASE LIST)_________________________________________________________________

-ANY OTHER DRUG ALLERGIES OR SENSITIVITIES_________________________________________________

ARE YOU PREGNANT?____________________________

PRESENT DENTAL PROBLEMS?______________________________________________________________

WHEN AND WHERE WERE YOUR LAST FULL MOUTH DENTAL XRAYS TAKEN?____________________________________________________________________________

WHEN WAS YOUR LAST DENTAL CLEANING?__________________________________________________

____________________________________________________

PATIENT SIGNATURE (Parent/guardian/caregiver if minor or disabled)

**Please do not leave anything blank. If nothing is applicable, please write N/A.**