509 W Hanley Ave, Ste 102
Coeur D'Alene, ID 83815

Patient Name_____ Birth date_____
Emergency Contact_____ Relationship_____
Name of Medical Doctor _____ Contact information_____
If you are completing this form for another person, what is your relationship? _____

Do you have any of the following diseases or problems?	Yes	No	DK
Exposure to Tuberculosis or active Tuberculosis	□	□	□
Cough that produces blood or persistent cough lasting over three weeks	□	□	□

Have you had a serious illness, operation or been hospitalized in the last five years? ____
If Yes what was the illness or problem? _____
Is there a history of cancer in your family? _____ Type _____
Are you taking or have you recently taken any prescription or over the counter medications ? _____
If so please list all including vitamins and diet supplements._____
_____
_____
_____

Please list medications that you have had an allergic reaction to: _____
_____

Please circle any of these medications that you have taken. Fosamax Actonel Aredia Zometa Bisphosphonate Fen-Phen

Do you use tobacco? _____ Approximate amount per day _____

Do you currently use controlled substance or have a history of drug abuse? _____

Have you ever had a total joint replacement? _____ If yes Date and type _____

Have you ever been instructed to premedicate? _____

Do you have the name and Phone number of the physician or surgeon who made this recommendation? _____

Please continue on page two

Please circle any of these conditions that you have been diagnosed with.
Artificial heart valve, Infective endocarditis, Congenital heart disease

Please circle or list any medical conditions you may have. Examples include Asthma, Bleeding Problems, Cancer, Diabetes, Heart Murmur, High Blood Pressure, COPD, Kidney Disease, Liver Disease, Psychiatric Treatment, Sinus Trouble, Stroke, Ulcers, History of Rheumatic Fever, Acid Reflux, Heart attack, AIDS, Hepatitis, Epilepsy, Arthritis, TMJ, Thyroidism

_____

_____

_____

Are you aware of any nighttime habits such as; Snoring, Tooth grinding, TMJ popping clicking or locking up _____

Pregnant or expecting to get pregnant soon? _____ Due _____

NOTE: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/ Legal guardian: Date:

_____ _____