First Name:___________________________________ Last Name:_______________________________ Number:_______________________

Address:____ Insurance:______________________________ ID:___________________

Patient's preferred pharmacy: ____ Pharmacy phone: ______________________________

Physician:____ Physician's phone: _______________________________

1. List of Medications you are taking: (If you have a list we can copy, please give to front desk)

Medication:	Dosage:	Reason:	Medication:	Dosage:	Reason:

2. List of Surgeries, Hospitalizations or Medical Procedures:

(If you have a list we can copy, please give to front desk)

Care Received:	Date:	Doctor:

4. List any medical conditions or history not listed above:

____

____

____

6. Are you currently on Medicinal Marijuana? ☐YES ☐NO

7. **Are you currently using Tobacco products?** ☐YES ☐NO

8. **Are you currently taking or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?** ☐YES ☐NO

3**. Are you allergic to, or have you had any reaction to, the following:**

Aspirin	☐YES	☐NO
Codeine	☐YES	☐NO
Local anesthetics	☐YES	☐NO
Penicillin	☐YES	☐NO
Sulfa drugs	☐YES	☐NO
Sedatives	☐YES	☐NO
Iodine	☐YES	☐NO
Any metals	☐YES	☐NO
Latex rubber	☐YES	☐NO
Acrylic	☐YES	☐NO

Other antibiotics :____

Other: ____

WOMEN ONLY: Are you pregnant?	☐YES	☐NO
Are you trying to get pregnant?	☐YES	☐NO
Are you taking oral contraceptives?	☐YES	☐NO
Are you nursing?	☐YES	☐NO

9. Do you have or have you had any of the following:

Aids/hiv positive	☐YES ☐NO	Excessive bleeding	☐YES ☐NO	Mitral valve prolapse	☐YES ☐NO
Alzheimer's disease	☐YES ☐NO	Excessive thirst	☐YES ☐NO	Osteoporosis	☐YES ☐NO
Anaphylaxis	☐YES ☐NO	Fainting spells/dizziness	☐YES ☐NO	Pain in jaw joints	☐YES ☐NO
Anemia	☐YES ☐NO	Frequent cough	☐YES ☐NO	Parathyroid disease	☐YES ☐NO
Angina	☐YES ☐NO	Frequent diarrhea	☐YES ☐NO	Psychiatric care	☐YES ☐NO
Arthritis/gout	☐YES ☐NO	Frequent headaches	☐YES ☐NO	Radiation treatments	☐YES ☐NO
Artificial heart valve	☐YES ☐NO	Glaucoma hay fever	☐YES ☐NO	Recent weight loss/gain	☐YES ☐NO
Artificial joint	☐YES ☐NO	Heart attack/failure	☐YES ☐NO	Renal dialysis	☐YES ☐NO
Asthma	☐YES ☐NO	Heart murmur	☐YES ☐NO	Rheumatic fever	☐YES ☐NO
Blood disease	☐YES ☐NO	Heart pacemaker	☐YES ☐NO	Rheumatism	☐YES ☐NO
Blood transfusion	☐YES ☐NO	Heart trouble/disease	☐YES ☐NO	Scarlet fever	☐YES ☐NO
Breathing problem	☐YES ☐NO	Hemophilia	☐YES ☐NO	Shingles	☐YES ☐NO
Bruise easily	☐YES ☐NO	Hepatitis A	☐YES ☐NO	Sickle cell disease	☐YES ☐NO
Cancer ____________	☐YES ☐NO	Hepatitis B or C	☐YES ☐NO	Sinus trouble	☐YES ☐NO
Chemotherapy	☐YES ☐NO	Herpes	☐YES ☐NO	Spina bifida	☐YES ☐NO
Chest pains	☐YES ☐NO	High blood pressure	☐YES ☐NO	Stomach/intestine disease	☐YES ☐NO
Cold sores/fever blisters	☐YES ☐NO	High cholesterol	☐YES ☐NO	Stroke	☐YES ☐NO
Congenital heart disease	☐YES ☐NO	Hives or rash	☐YES ☐NO	Swelling of limbs	☐YES ☐NO
Convulsions	☐YES ☐NO	Hypoglycemia	☐YES ☐NO	Thyroid disease	☐YES ☐NO
Cortisone medicine	☐YES ☐NO	Irregular heartbeat	☐YES ☐NO	Tonsilitis	☐YES ☐NO
Diabetes	☐YES ☐NO	Kidney problems	☐YES ☐NO	Tuberculosis	☐YES ☐NO
Drug addiction	☐YES ☐NO	Leukemia	☐YES ☐NO	Tumors or growths	☐YES ☐NO
Easily winded	☐YES ☐NO	Liver disease	☐YES ☐NO	Ulcers	☐YES ☐NO
Emphysema	☐YES ☐NO	Low blood pressure	☐YES ☐NO	Other ________________	
Epilepsy or seizures	☐YES ☐NO	Lung disease	☐YES ☐NO		

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes, Derek M. Winegar, DDS or Chantel Keller, DDS to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Derek M. Winegar, DDS to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Derek M. Winegar, DDS or Chantel Keller, DDS choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Derek M. Winegar, DDS or Chantel Keller, DDS. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

Signature:____ Date:___________________________________