HUBBELL J. SMITH, DDS
GENERAL DENTIST

Patient's name _____

Date of Birth _____ Name and phone number of usual pharmacy _____

Do you have an allergy to any type of antibiotic? If yes, list here _____

1. Are you under the care of a physician at this time? _____ YES NO

   If yes, for what condition? _____

2. The name and address of physician is: _____

   _____

3. My last physical exam was on _____

4. Has a physician treated you in the past six months? _____ YES NO

   If yes, for what condition? _____

5. Have you been hospitalized or had a serious illness with the last five years? _____ YES NO

   If yes, please specify: _____

6. Are you allergic or had any adverse reaction to any medicines, drugs, local anesthetics, LATEX or other substances? _____

   _____ YES NO

   If yes, please specify: _____

7. Do you have or have you had any of the following diseases/problems? Please explain YES answers on the back

A. Abnormal, bleeding, bruise easily or require blood transfusion……YES NO
B. Angina/Chest Pain ……YES NO
C. Asthma/Lung/Respiratory condition……YES NO
D. Diabetes ……YES NO
E. Emotional/Mental health disorder ……YES NO
F. Epilepsy/Seizures/convulsions ……YES NO
G. Hepatitis/Jaundice/Cirrhosis/Liver disease……YES NO
H. High blood pressure ……YES NO
I. HIV positive/AIDS……YES NO
J. Hives or skin rash ……YES NO
K. Kidney/Renal disease ……YES NO
L. Sexually Transmitted Disease(s)……YES NO
M. Stomach ulcers ……YES NO
N. Thyroid Disease ……YES NO
O. Tuberculosis……YES NO
P. Artificial/Prosthetic joint replacement ……YES NO
Q. Artificial/Prosthetic heart valves ……YES NO
R. Valve damage following heart transplant ……YES NO
S. Congenital heart defect ……YES NO
T. Infective endocarditis ……YES NO
U. Heart murmur ……YES NO
V. Mitral valve prolapsed ……YES NO
W. Rheumatic heart disease ……YES NO
X. Congestive heart failure ……YES NO
Y. Pacemaker ……YES NO
Z. Cardiovascular (heart) disease, arteriosclerosis coronary occlusion ……YES NO
AA. Cancer/Chemo/Radiation therapy……YES NO
BB. Immune suppression or deficiency ……YES NO
CC. Heart attack date……YES NO
DD. Heart surgery date ……YES NO
EE. Stroke date ……YES NO
FF. GERD (Gastro esophageal reflux disease) ……YES NO

8. Have you had any surgery or radiation treatment for a tumor, growth or other condition of your head or neck? _____ YES NO
   If yes, please list _____

9. Do you have any other disease, conditions or problems not listed above? If yes, please explain _____

   _____

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10. Are you taking or have you ever taken any of the following medications for any type of cancer, osteoporosis, or bone loss due to aging, Paget's Disease or multiple myeloma? _____ YES NO

    If yes, please check the appropriate medications below:

    Non-nitrogen containing (less potent) Bisphosphonates – Oral
    Etidronate (Didronel, Didrocal)
    Tiludronate (Skelid)

    Nitrogen Containing Diphosphonates – oral
    Pamidronate (Aredia, Rhoxal)
    Zoledronate (Zometa, Aciasta, Reclast)
    Clodronate (Bonefos)
    Neridronate

    Nitrogen Containing Bisphosphonates - IV
    Alendronate (Fosamax, Fosamax +D, Fosavance)
    Ibandronate (Boniva, Bondronat)
    Risedronate (Actonel)
    Olpadronate

    (This list of Bisphosphonate medications should not be considered complete as new drugs are continually being developed)

11. Please list any medications, pills, or drugs with the dosage which you are taking both prescription and nonprescription:

Trade Name	Generic Name	Dose/Frequency	Reason

12. Have you had any trouble associated with previous dental treatment? _____ _____ YES NO

13. Do you have any lumps or sores in your mouth now? _____ YES NO

14. Do you smoke or use smokeless tobacco? _____ YES NO

15. How often do you have dental checkups? _____ Date of last exam _____

16. WOMEN ONLY: Are you pregnant? _____ YES NO

    If yes, when is your expected due date? _____

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely.

PATIENT'S SIGNATURE: _____ Date Signed: _____

If a family member or designated caretake has helped in filling out this form, please print your name and relationship to patient:

_____