Confidential Patient Information and Medical History

Patient Name: _____
Date of Birth (dd/mm/yyyy): _____
Home Address: _____
City: _____
Postal Code: _____

Home Telephone: _____
Cell Phone: _____
Best Number to Contact You: _____

Email Address: _____

Marital Status: _____

Employer: _____
Occupation: _____
Business Address: _____
Business Phone: _____

Emergency contact Name: _____
Relationship: _____
Phone Number: _____

General Dentist Name: _____
Referred by: _____

Do you have dental insurance? ☐ Yes ☐ No

Family Physician Name: _____
Phone Number: _____

Pharmacy: _____
Phone Number: _____

When was your last physical exam? _____
Are you in good health? ☐ Yes ☐ No
Has there been any change in your health in the last year? ☐ Yes ☐ No
If yes, please elaborate: _____
_____

Has it ever been recommended that you routinely have antibiotic coverage before surgery or dental treatment? ☐ Yes ☐ No

Please list **ALL** medications that you are currently taking:

_____
_____
_____
_____
_____
_____

Are you *allergic* or have you reacted adversely to any of the following?

Aspirin	☐ Yes ☐ No	Codeine or other narcotics	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No	Sedatives or sleeping pills	☐ Yes ☐ No
Tetracycline	☐ Yes ☐ No	Local anesthetics	☐ Yes ☐ No
Other antibiotics	☐ Yes ☐ No	Latex gloves	☐ Yes ☐ No

Other allergies (please list): _____

Do you smoke? ☐ Yes ☐ No
If so, how many cigarettes/day? _____
How many years have you smoked? _____

Are you a former smoker? ☐ Yes ☐ No
If so, how many cigarettes/day? _____
How many years did you smoke? _____
How long ago did you quit? _____

Do you or have you had any of the following conditions?

High Blood Pressure/Heart Trouble	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No
Mitral Valve Prolapse (MVP)	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Heart Surgery or Heart Attack	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Excessive Bruising	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Hemophilia or Blood Transfusion	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No
Emphysema/Bronchitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hayfever	☐ Yes	☐ No
Sinus Troubles	☐ Yes	☐ No

Diabetes or Excessive Thirst	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No
Stomach Ulcer	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Hepatitis A/B/C	☐ Yes	☐ No
Yellow Jaundice	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
HIV (AIDS)	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Cold Sores	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No
Alcohol Dependency	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Eating Disorders	☐ Yes	☐ No
Psychiatric Treatment	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Rheumatic or Scarlet Fever	☐ Yes	☐ No

Have you ever been hospitalized? ☐ Yes ☐ No
If so, why? _____

Are there any medical conditions that run in your family (i.e., high blood pressure, diabetes, cancer)? ☐ Yes ☐ No
If so, what? _____

Have you ever had abnormal bruising or bleeding associated with previous extractions, surgery, or injury? ☐ Yes ☐ No

Have you ever had any serious trouble with any previous dental treatment? ☐ Yes ☐ No

Do you have any disease, condition, or problem not listed above that we should be made aware of? ☐ Yes ☐ No
If so, what? _____

Women only: Are you pregnant? ☐ Yes ☐ No
If so, what month are you due? _____

Women only: Are you nursing? ☐ Yes ☐ No

Are you willing to spend 15 minutes a day to keep your teeth for a lifetime? ☐ Yes ☐ No

On a scale of 1 to 5, how nervous are you about dental treatment? (Please circle)

(Not nervous at all) 1…….2…….3…….4…….5 (Very nervous)

I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge. I consent to your obtaining, from other practitioners who are currently treatment me or have treated me, such further information as may be necessary for providing me with proper dental treatment and care.

Signature: _____ Date: _____

D.D.S.: _____

Please be advised that our office policy is not to accept assignment of benefits as payment for accounts.

☐ Please check this box if you DO NOT want your information included in a future research study. Your decision will in no way impact the care you receive.

Supplement Questionnaire

Patient Name: _____
Date: _____

Supplement	Dose	Brand	Frequency	Duration
B vitamin complex				
Beta-carotene				
Calcium				
Chondroitin				
Copper				
Dong Quai				
Echinacea				
Fish oil (DHA or EPA)				
Omega 3, 6, 9				
Cod Liver oil				
Flaxseed (ground)				
Flaxseed (unground)				
Flaxseed oil				
Folic acid (Folate)				
Garlic				
Ginko				
Glucosamine				
Goldenseal				
Green tea				
Iron				
Kava				
Lycopene				
Magnesium				
Multivitamin/multimineral				
Selenium				
St. John's wort				
Valerian root				
Vitamin B6				
Vitamin B12 (oral or injection)				
Vitamin C				
Vitamin D				

Vitalux (for eye health) _____

Zinc _____

Other (please list): _____

_____

_____

_____

Dr. Fritz is committed to providing his patients with evidence-based care. In doing so, there may be research questions that he would like to answer using data collected during your visit to improve future patient care. Please know that in using such information your personal identity would not be revealed.

☐ Please check this box if you DO NOT want your information included in a future research study. Your decision will in no way impact the care you receive.