Dent Art Dental Center

PATIENT INFORMATION FORM

Please complete all information on this form.

_____ _____ / _____

Full Legal Name (PLEASE PRINT FIRST, MIDDLE AND LAST) **Male** **Female**

_____

Residential Address

_____ _____ / _____

City **State** **Zip**

_____ _____ _____ _____ _____ _____

Date of Birth **Height** **Weight** **Age** **Home Phone** **Cell Phone**

_____

Occupation

_____ _____

Business Phone **Email**

DENTAL HISTORY

Do you have any (Major Medical Problems) ? Yes _____ No _____

Please explain: _____

_____

Is there any chance you could be pregnant ? Yes _____ No _____

Are you currently taking, or have ever taken any Bisphosphonates or other medication for osteoporosis ? Yes _____ No _____

Please list current or past prescribed Bisphosphonate grug(s) For example: Actonel, Boniva, Fosomax, skelid ?

_____

Have you ever been treated for periodontal gum disease ? Yes _____ No _____

Do you have a family dentist ? Yes _____ No _____

Dentist Name : _____ **Last visit :** _____

What is your main dental concern on your visit today : _____

How is your current dental condition affecting you : _____