Welcome to Our Practice

Patient Name: (Last)_____ (First) _____ MI _____

Gender: M/F Email Address: _____

Phone: (H)_____ (W)_____ Mobile _____

Mailing Address: _____

City: _____ Postal Code: _____

Birthdate: (d/m/y) _____

Insurance Information:

Policy Holder: _____Birthdate of Policy Holder: d/m/y _____

Insurance Company: _____

Group Number: _____Certificate (ID)Number _____

Secondary Insurance

Policy Holder: _____Birthdate of Policy Holder: d/m/y _____

Insurance Company: _____

Group Number: _____Certificate (ID)Number _____

Medical History

Boisson Dental Group
Rooted in the Peace

Indicate which of the following conditions you have or have had. By checking the box, it will indicate a "Yes" response, leave it blank will indicate a "NO" response.

	Pre-Medication		Allergy (See Notes)		Allergy - Aspirin
	Allergy – Codeine		Allergy (Iodine)		Allergy - Latex
	Allergy - Penicillin		Allergy (Sulfa)		Allergy - Erythromycin
	Artificial Joints		Anemia		Arthritis
	Cancer		Asthma		Blood Disease
	Dizziness/Fainting		Contraceptive Use		Diabetes
	Excessive Bleeding		Emphysema		Epilepsy
	Glaucoma		Excessive Bruising		Gastro-Intestinal
	Head Injury		Hard to Freeze		Hay Fever
	Heart Murmur		Hearing Disabled		Heart Disease
	Hepatitis C		Hepatitis A		Hepatitis B
	Hives		High Blood Pressure		HIV + (AIDS)
	Liver Disease		Jaundice		Kidney Disease
	Multiple Sclerosis		Low Blood Pressure		Anxiety
	Pacemaker		Nervous Disorders		Other (add to notes)
	Respiratory Problems		Bisphosphonate Treatment (Fosamax) – Osteoporosis		Radiation Treatment
	Rheumatoid Arthritis		Rheumatic Fever		Rheumatism
	STD		Sinus Problems		Skin Rash
	Thyroid Disease		TMJ		Stroke
	Tumors		Ulcers		Tuberculosis
	Ever Been Hospitalized (illness or injury)		Subject to frequent headaches		Presently being treated for other illnesses
	Tobacco/Alcohol Use		Female: Birth control		Female: Currently Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of your physician and phone number: _____

What is your estimate of your general health? Excellent/Good/Fair/Poor (Circle one)

List all medications (prescription and non-prescription) including regular does of aspirin:

* By signing this form, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature: _____ Response Date: _____