Tilger Center for Dentistry, P.A.

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Although some of the following questions may seen unrelated to your teeth, they are associated with proper management of your oral health and are confidential. Please check all that apply to you in th past and present.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

☐ *Allergic to Asprin	☐ *Allergic to Codeine	☐ *Allergic to Iodine	☐ *Allergic to Latex
☐ *Allergic to PenVK	☐ *Allergic to Sulfa	☐ *Allergies	☐ Abnormal Bleeding
☐ AIDS/HIV	☐ Anemia	☐ Angina/ Chest Pain	☐ Arthritis
☐ Artificial Joints	☐ Artificial Valve	☐ Asthma	☐ Auto Immune Disorder
☐ Blood Disease	☐ Blood Transfusion	☐ Cancer	☐ Chemotherapy
☐ Defibrillator	☐ Diabetes	☐ Dizziness	☐ Emphysema
☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Fainting	☐ Frequent Headache
☐ Gallbladder	☐ Glaucoma	☐ Hay Fever	☐ Head Injuries
☐ Heart Disease	☐ Heart Murmur	☐ Heart Surgery	☐ Hepatitis
☐ High Blood Pressure	☐ Jaundice	☐ Jaw Pain	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders	☐ MitralValve Prolapse
☐ Nervous Disorders	☐ Neurolog. Disorder	☐ Organ Transplant	☐ Organ Transplant
☐ Pacemaker	☐ Persistant cough	☐ Pre- Medication	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Shortness of Breath	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke/TIA	☐ Thyroid Problem	☐ Tonsilitis
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

Family History of Diabetes? ◯ Yes ◯ No

Frequent Nose Bleeds? ◯ Yes ◯ No

Oral Herpes or cold sores? ◯ Yes ◯ No

Pregnant?
If Yes -Due Date? _____

Have you ever or are you currently taking any bone loss prevention medications? (Fosamax, Actonel, Boniva, Reclast, Prolia) ◯ Yes ◯ No

Please explain any checked boxes:

Please list all medications you are currently taking including dosage and frequency:

Please provide the location and phone number of your preferred Pharmacy *

Do you have any allergies to medication other than what is listed above?

Do you have a Primary care Physician? If yes, please provide your Doctor's name and phone number

Please list any concerns regarding your teeth, mouth or dental history:

Has there been an accident or medical event that may be the cause for you being here today? If yes, please explain:

☐ ***By checking this box, I acknowledge that I have read this statement and agree to the contents.**

Signature *

Date: *

Response Date: ___/___/_____