Dental Excellence of Napoleon

Dr. Michael D. Carpenter

Date: ____________________

Name: ____________________

Date of Birth: ____________________

Address: ____________________

City, State & Zip: ____________________

Social Security No.: ____________________

Home Phone: ____________________

Cell Phone: ____________________

E-Mail Address: ____________________

Occupation: ____________________

Employer: ____________________

Work Phone: ____________________

Do You Have Dental Insurance? Yes ☐ No ☐

If Yes, Name: ____________________

Marital Status:
- Single: ☐
- Married: ☐
- Divorced: ☐
- Widowed: ☐

Who may we contact in case of emergency?

Name: ____________________

Telephone: ____________________

Relationship: ____________________

Physician's Name: ____________________

Person financially responsible for this account if other than patient? ____________________

	Yes	No
Do you have any general health problems?	☐	☐

If so, please specify. ____________________

	YES	NO
Are you now or have you ever taken oral bisphosphonate medications including Fosamax, Actonel or Boniva?	☐	☐
Are you currently taking any other medication or drugs including birth control medication?	☐	☐

If so, what? ____________________

To the best of your knowledge, are you or have you ever been afflicted with:

	YES	NO
Chest Pains	☐	☐
Heart Attack	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Heart Murmur	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Rheumatic fever	☐	☐
Epilepsy	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease	☐	☐
Asthma	☐	☐
TB or Hepatitis	☐	☐
Prolonged Bleeding or Healing Complications	☐	☐
Thyroid Problems	☐	☐
Glaucoma	☐	☐
Joint replacement or implant	☐	☐
Arthritis	☐	☐
Cancer	☐	☐

If yes, have you had:

	YES	NO
Metastatic Breast Cancer;	☐	☐
Metastatic Prostate Cancer	☐	☐
Multiple Myeloma;	☐	☐
Past or current chemotherapy;	☐	☐
The intravenous medications Zometa, Aredia or Bonefos;	☐	☐

	YES	NO
Are you pregnant or think you may be pregnant?	☐	☐

To the best of your knowledge, are you or have you ever been allergic to:

	YES	NO
Local anesthetics (e.g. Novacaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sedatives (e.g. Valium)	☐	☐
Aspirin	☐	☐
Ibuprofen	☐	☐
Tylenol	☐	☐
Any metals	☐	☐
Latex	☐	☐
Any other drug	☐	☐

If yes, what? ____________________