

**Kristen J. Frantz, D.M.D., M.S. & Bryan J. Frantz, D.M.D., M.S**

**PATIENT NAME** \_\_\_\_\_ **Date Of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**ADDRESS** \_\_\_\_\_

**Home Phone #** \_\_\_\_\_ **Cell #** \_\_\_\_\_ **Work #** \_\_\_\_\_

**Emergency Contact #/Name** \_\_\_\_\_ **Email address** \_\_\_\_\_

**Name of who referred you to our office** \_\_\_\_\_

**What dental problems are you currently experiencing?** \_\_\_\_\_

\_\_\_\_\_

**Do you have any current medical problems?** \_\_\_\_\_

**Do you premedicate for dental visits?** \_\_\_\_\_

**If yes, why do you & what antibiotic** \_\_\_\_\_

**Please list your medications with dose and frequency:** \_\_\_\_\_

\_\_\_\_\_

**Please list any dental surgical procedures you've had:** \_\_\_\_\_

\_\_\_\_\_

**Do you have any food, drug or latex allergies? Yes or No If yes, please list them and what reaction you've had.** \_\_\_\_\_

**Have you ever had any issues with the following conditions?**

\_\_\_\_ High Blood Pressure      \_\_\_\_ Autoimmune Disease      \_\_\_\_ Hepatitis \_\_\_\_ Type

\_\_\_\_ Heart Attack/Angina/Stents      \_\_\_\_ Arthritis      \_\_\_\_ Rheumatic Fever

\_\_\_\_ Emphysema      \_\_\_\_ Hearing Loss      \_\_\_\_ Cancer

\_\_\_\_ Diabetes Mellitus      \_\_\_\_ Allergies      \_\_\_\_ Headaches

\_\_\_\_ High Cholesterol      \_\_\_\_ Asthma      \_\_\_\_ Visual Disorders

\_\_\_\_ Heart Murmur      \_\_\_\_ Kidney Stones/Disease      \_\_\_\_ Shortness of Breath

**Have you ever had any issues with the following conditions:**

- |                                  |  |
|----------------------------------|--|
| _____ Valve Replacement          | _____ Gout   |
| _____ Joint Replacement          | _____ Thyroid Disease  |
| _____ Blood Transfusion          | _____ Osteoporosis & Treatment   |
| _____ Chest Pain/Palpitations    | _____ Sinus Problems/Polyps/Nose Bleeds  |
| _____ Unexplained Weight Loss    | _____ Excessive Thirst or Hunger   |
| _____ HIV or Infectious Diseases | _____ Urinary Frequency/Discomfort/Blood   |
| _____ Dry Mouth                  | _____ Treatment with intravenous or injectable<br>drugs including Prolia and weight loss drugs |

**Is there any family history of:**

- |                                   |                         |
|-----------------------------------|-------------------------|
| _____ Cancer or Blood Disorders   | _____ Loss of teeth     |
| _____ Heart Disease               | _____ Bleeding Problems |
| _____ Tuberculosis                | _____ Hypertension      |
| _____ Periodontitis/Oral problems |                         |

Do you smoke Cigarettes? \_\_\_\_\_ If yes, how many years \_\_\_\_\_ Do you Vape? \_\_\_\_\_

Are you a Former Smoker? \_\_\_\_\_ If yes when did you quit \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ Estimate Frequency & Quantity \_\_\_\_\_

Any history of drug abuse or addiction? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ Estimate your daily caffeine intake \_\_\_\_\_

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**Patient's Signature**

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**Date**