



**5280 Dental**  
*Smiles above the rest*  
 Erich Zimmermann, DDS

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Preferred Name \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

What is the best way to contact you? \_\_\_\_\_

DOB: \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Tell us what's important to you in finding a dentist.

**MEDICAL HISTORY**

Are you now or have you recently been under a physician's care?      yes      /      no

Reason \_\_\_\_\_

Check any of the following medical conditions you may have had:

- |                                                  |                                                                |                                                         |
|--------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Artificial Heart Valve/Pacemaker      | <input type="checkbox"/> Prolonged Bleeding             |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Artificial Joints (hip, knee, etc...) | <input type="checkbox"/> Fainting or Dizzy Spells       |
| <input type="checkbox"/> Heart Trouble           | <input type="checkbox"/> Cancer or Tumor                       | <input type="checkbox"/> Epilepsy                       |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Tuberculosis                          | <input type="checkbox"/> Thyroid Problems               |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Glaucoma                       |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Kidney/Bladder Trouble                | <input type="checkbox"/> Radiation Treatment            |
| <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Liver Disease                         | <input type="checkbox"/> Psychiatric/Psychological Care |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Lung Disease                          | <input type="checkbox"/> HIV or AIDS                    |
| <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Venereal Disease                      | <input type="checkbox"/> Anemia                         |
| <input type="checkbox"/> Asthma or Hay Fever     | <input type="checkbox"/> Blood Disease                         | <input type="checkbox"/> Blood Transfusion              |
| <input type="checkbox"/> Sinus trouble           | <input type="checkbox"/> Hepatitis or Jaundice                 |                                                         |

Are you taking any medications?      yes      \_\_\_\_\_      no      \_\_\_\_\_

If yes, please list \_\_\_\_\_

Have you ever taken Fosamax or any Bisphosphonates?      yes / no

Are you aware of having an **allergic (or adverse)** reaction to any substance or medication?      yes / no

If yes, please list \_\_\_\_\_

Are you pregnant?      \_\_\_\_\_ yes      \_\_\_\_\_ no      If yes, how many months? \_\_\_\_\_

Are you breast feeding? \_\_\_\_\_

Yes, you may use my testimonial, photos and name to let other patients know about my great experience with your office

Patient's signature \_\_\_\_\_