Dr. Mark A. Herzog DDS

Patient Information

Patient Name_____ Date of Birth ___/___/___

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Sex_____

Martial Status (circle): married, single, widowed, divorced

Driver License #_____ Social Sec. #_____

Employer_____ Work Phone_____

Address_____ City_____ State_____ Zip_____

Spouse's Name (for minors) _____

Date of Birth ___/___/___ Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

Employer_____ Work Phone_____

In Case of Emergency
not living with you

Contact Name_____ Phone_____

Relationship to Patient_____

Patient Signature_____ Date ___/___/___

Medical History

Are you under a physician's care? yes no if yes_____

Have you ever been hospitalized/had a major operation? yes no if yes_____

Have you ever had a serious head/neck injury? yes no if yes_____

Are you taking any medications? yes no if yes_____

Have you ever had a joint replacement surgery?
If yes, are you required to take A pre-med for dental procedures? yes no

Do you/have to take Phen-Fen or Redux? yes no

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? yes no

Do you use tobacco? yes no

Women: Are you trying…(circle)

Pregnant/Trying to get Pregnant Nursing Taking Oral Contraceptives

Are you allergic to any of the following? (circle)

Aspirin Penicillin Codeine Acrylic Latex

Sulfa Drugs Local Anesthetics Metal

Any other allergies? yes no if yes_____

Do you use controlled substances? yes no if yes_____

Do you have any of the following?

AIDS/HIV Positive	yes	no
Alzheimer's Disease	yes	no
Anaphylaxis	yes	no
Anemia	yes	no
Angina	yes	no
Arthritis/Gout	yes	no
Artificial Heart Valve	yes	no
Artificial Joint	yes	no
Asthma	yes	no
Blood Disease	yes	no
Blood Transfusion	yes	no
Frequent Headaches	yes	no
Low Blood Pressure	yes	no
Lung Disease	yes	no
Mitral Valve Prolapse	yes	no
Osteoporosis	yes	no
Pain in Jaw Joints	yes	no
Parathyroid Disease	yes	no
Psychiatric Care	yes	no
Cortisone Medicine	yes	no
Diabetes	yes	no
Drug Addiction	yes	no
Easily Winded	yes	no
Emphysema	yes	no
Epilepsy/Seizure	yes	no
Excessive Bleeding	yes	no
Excessive Thirst	yes	no
Fainting Spells/Dizzy	yes	no
Frequent Cough	yes	no
Leukemia	yes	no
Liver Disease	yes	no
Swelling of Limbs	yes	no
Thyroid Disease	yes	no
Tonsillitis	yes	no
Tuberculosis	yes	no
Hepatitis A	yes	no
Hepatitis B	yes	no
Hepatitis C	yes	no
Herpes	yes	no
High Blood Pressure	yes	no
High Cholesterol	yes	no
Hives/Rash	yes	no
Hypoglycemia	yes	no
Irregular Heartbeat	yes	no
Kidney Problems	yes	no
Stomach/Intestinal	yes	no
Stroke	yes	no
Cancer	yes	no
Chemotherapy	yes	no
Chest Pains	yes	no
Cold Sores	yes	no
Heart Disorder	yes	no
Convulsions	yes	no
Yellow Jaundice	yes	no
Radiation Treatment	yes	no
Recent Weight Loss	yes	no
Renal Dialysis	yes	no
Rheumatic Fever	yes	no
Rheumatism	yes	no
Scarlet Fever	yes	no
Shingles	yes	no
Sickle Cell Disease	yes	no
Sinus Trouble	yes	no
Spina Bifida	yes	no
Breathing Problems	yes	no
Bruise Easily	yes	no
Glaucoma	yes	no
Hay Fever	yes	no
Heart Attack/Fail	yes	no
Heart Murmur	yes	no
Heart Pacemaker	yes	no
Heart Trouble	yes	no
Ulcers	yes	no
Venereal Disease	yes	no
Hemophilia	yes	no
Tumors/Growth	yes	no

Do you have any dental/pain discomfort? yes no

I understand that providing the incorrect information can be dangerous to my health. It is my responsibility to inform the dental

Signature_____ Date___/___/___