



Online Registration: <https://enabledental.com/new-patient-registration/>
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Questions? Call us at: (866) 988-4504

New Patient Dental/Health History

Required for patients who reside at a personal residence

PATIENT NAME _____ PATIENT DATE OF BIRTH _____

PATIENT MEDICAL HISTORY (CHECK IF THE PATIENT HAS OR HAS EVER HAD)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies, hay fever, sinusitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Arthritis Rheumatism | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Slow healing wounds |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial joints; Surgery Date: _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bleeding abnormally with operations or surgery | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood disease, clotting disorders | <input type="checkbox"/> Any immune deficiency | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tumor or growth on head/neck |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Weight loss, unexplained |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Osteoporosis | Allergies |
| <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Allergic to Aspirin |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Allergic to Penicillin |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Radiation treatments (specify if head/neck) | <input type="checkbox"/> Allergic to latex |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Allergic to sulfa drugs |
| <input type="checkbox"/> Fainting or fall risk | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Allergic reaction to Novocain, local, or general anesthetics? |
| | <input type="checkbox"/> Scarlet fever | |

If "Yes" to any of the above, please describe: _____

Is the patient currently taking prescription blood thinners? Yes No Uncertain

If "Yes", specify _____

Has the patient ever taken medications or received injections for osteoporosis (bisphosphonates)? Yes No Uncertain

Has the patient ever been prescribed an antibiotic pre-medication for a dental visit? Yes No

List any medications that the patient is taking: _____

List any known allergies the patient has: _____

Primary Care Physician / MD: _____ Contact Information: _____

Are there any additional concerns? _____