Online Registration: https://enabledental.com/new-patient-registration/
Email to: info@enabledental.com
Fax to: (866) 815-3719
Mail to: 5555 N Lamar Blvd, Ste H125, Austin, TX 78751
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)

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

Allergies

- ☐ Allergic to Aspirin
- ☐ Allergic to Penicillin
- ☐ Allergic to latex
- ☐ Allergic to sulfa drugs
- ☐ Allergic reaction to Novocain, local, or general anesthetics?

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? _____

Name: _____

Signature: _____ Date _____