Provider Intl:_____

DEXTER DENTAL STUDIO

Healthy Mouth. Healthy Body. Healthy Mind.

If there have been any CHANGES to your ADDRESS or INSURANCE, please speak with the front desk.

Patient Name:_____ **E-mail:**_____

Preferred Phone Number:_____ **Circle one:** Home Cell Work

Patient (*or Guardian*) **Signature**: _____**Date:**_____

Your Physician's Name: _____**Phone:**_____

Current Gender Identity: ☐Male ☐Female ☐Transgender Male/Transman/FTM ☐Transgender Female/Transwoman/MTF ☐Gender Queer ☐Other (Please Specify:_____)

Preferred Gender Pronoun: ☐She/her/hers ☐He/him/his ☐They/them/theirs ☐Other (Please Specify:_____)

The following information is ESSENTIAL for YOUR safe diagnosis and treatment

Circle *conditions/diseases that you currently have or have had in the past.*

Heart	**Respiratory**	**Gastro-Intestinal**
Congenital Heart Disease	Asthma	Kidney Disease
Bacterial Endocarditis	Breathing Problem(s)	Liver Disease/Jaundice
Heart Attack: _____	Sleep Apnea	Ulcers
Irregular Heart beat	Snoring	Intestinal or Stomach Disease
Angina/ Chest Pain	Shortness of Breath	Gastric Reflux
Heart Surgery	Cough	
Artificial Heart Valve	Oxygen Dependent	
Heart Pacemaker	Tuberculosis	
High or Low Blood Pressure	Emphysema	
High Cholesterol		

Neurology	**Hematology**	**Endocrine**
Convulsions/Seizures/Epilepsy	Bleeding/Bruising Easily	Diabetes Type I Type II
Numbness or Tingling Back Pain	Blood Disorder	Hypoglycemia
Psychiatric Treatment	Autoimmune Disorder	Steroid Treatment *(Cortisone)*
Fainting/Dizziness	Lupus/Sjogren's	Thyroid Disease
MS (Multiple Sclerosis)		
Stroke		
Paralysis		
Migraines or Tension Headaches		

Musculoskeletal	**Infectious Diseases**	**General**
Arthritis/Rheumatism/Joint Pain	HIV	Cancer: _____
Artificial Joint: _____	AIDS	Radiation/Chemotherapy
Osteoporosis	Hepatitis A, B or C	Recent Weight Loss/Gain
Fosamax, Actonel, Boniva	Herpes/Cold Sores	Eye/Hearing Problems
Head/Neck Injury	HPV	Drug/Alcohol/Tobacco Use
Scleroderma		Marijuana Use
		Interested in Quitting: Y N

*****Women ONLY***** Pregnant/Trying to get pregnant Nursing Taking Oral Contraceptives

Other Medical Conditions NOT Listed: _____

Patient Name:_____Date:_____Provider Intl:_____

We require the following information as a yearly update for your safe treatment. IF you carry a list of your medications, we are happy to photocopy it and you do not have to complete this form.*

Allergies		

Rx Medications		

Supplements & Vitamins		