Name___________________________________**Address**__________________________________
City________________**State**_________**Zip**_________**Home#**____________________________
Cell#___________________ **Work#**____________________ **Birth date**_____________ **Sex(M/F) Marital Status (S M D W)SS#**________________ **Employer**________________________________
Insurance (Yes / No) Referred By___________________________ **Email** ____________________

Are you under a Physicians care now? _YES Dr's Name & Number_________________________________
Pharmacy_____________________________________ Pharmacy Number#__________________________

Do you have a specific dental problem? **Yes No**	Do you have dental decay or gum disease? **Yes No**
Do you like your smile? **Yes No**	Do you have sores or growths in your mouth? **Yes No**
Do you smoke? **Yes No**	Do you take oral contraceptives? **Yes No**

Do you take **Bisphosphonates** for treatment of Cancer or Osteoporosis? Fosamax,or other medications such as (Aredia, IV Bondronat, Bonefos, Loron, Zometa, IV Reclast, IV Actenel, Didronel, Skelid). **Yes No**
Do you take aspirin or blood thinners? **Yes No (please list type)**______________________________________
LIST ALL YOUR MEDICATIONS:____
____
ALLERGIES: ( )Penicillin( )Sulfa( )Codiene( )Aspirin( )Latex( )Other:_____________________________
PLEASE check (**X**) if you have any of the following

	AIDS/HIV		Fainting/Dizziness		Osteoporosis
	Anaphylaxis		Glaucoma		Obstructed Sleep Apnea
	Anemia		Heart Attack		Psychiatric Care
	Angina		Heart Murmur		Radiation Treatment
	Arthritis/Gout		Heart Pacemaker		Renal Dialysis
	Artificial Heart Valve		Heart Stent(s)		Rheumatic Fever
	Artificial Joints		Heart Trouble		Shingles
	Asthma		Hepatitis		Sinus Trouble
	Blood Disease		High Blood Pressure		Stroke
	Blood Transfusion		History of Bleeding		Thyroid Problems
	Breathing Problems		Hypoglycemia		Tuberculosis
	Cancer		Irregular Heartbeat		CPAP Usage
	Chemotherapy		Kidney Problems		Bleeding Gums
	Diabetes		Leukemia		Venereal Disease
	Drug/Alcohol Addictions		Liver Disease		Sexually Transmitted Disease
	Emphysema		Low Blood Pressure		
	Epilepsy/Seizures		Mitral Valve Prolapse		

Please list any other medical conditions that were not listed_______________________________________
____
In case of an emergency please notify_______________________________Phone#____________________
DUPLICATE X-RAYS are available for $10.00 with a 24hr notice.
Permission is hereby granted to the doctor and/or staff of Leading Edge Dental for such procedures and

anesthesia that may be necessary for the care of the undersigned patient.

PATIENT SIGNATURE____DATE______________________

THERE WILL BE A $25.00 FEE FOR CANCELLED APPOINTMENTS WITHOUT A 24 HOUR NOTICE.